EFFECTIVENESS OF ASSERIVENESS TRAINING UPON ASSERTIVENESS SKILLS AND SELF-ESTEEM AMONG ALCOHOLIC PATIENTS

BY

JYOTHI. S. SUNANDHA

A DISSERTATION SUBMITTED TO THE TAMILNADU DR.M.G.R.MEDICAL UNIVERSITY, CHENNAI, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

APRIL 2012

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Approved by the Dissertation Committee on: _____

Research Guide : _____

Dr. Latha Venkatesan,
M.Sc (N)., M.Phil., Ph.D.,
Principal and Professor in Nursing,
Apollo College of Nursing,
Chennai - 600 095.

Clinical Guide **:** _____

Mrs. Vijayalakshmi.K.,
M.Sc (N).,
HOD Psychiatric Nursing,
Apollo College of Nursing,
Chennai – 600 095.

Medical Guide : _____

Dr. Bharathi Visveswaran,
M.D., D.P.M., F.I.C.P.,
Consultant psychiatrist,
Apollo Hospitals,
Chennai – 06.

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DECLARATION

I hereby declare that the present dissertation titled **"Effectiveness of Assertiveness Training upon the Assertiveness Skills and Self-Esteem among Alcoholic Patients in Selected De-addiction Centres, Chennai",** is the outcome of the original research work undertaken and carried out by me, under the guidance of **Dr. Latha Venkatasen, M.Sc (N)., M.Phil., Ph.D.,** Principal and Professor in Obstetric and Gynecological Nursing, Apollo College of Nursing and **Mrs. Vijayalakshmi. K, M.Sc (N).,** HOD, Psychiatric Nursing**,** Apollo College of Nursing, Chennai. I also declare that the material of this has not formed in any way, the basis for the award of any degree or diploma in this university or any other universities.

II-Year M.Sc (N) Student

ACKNOWLEDGEMENT

Working with sixty clients in close contact for one month has been a fascinating experience. They showed me the harsh reality, the tears and pain that goes along with the menace called alcoholism. The challenges they posed during the therapy has made me realize the need to have the best effective intervention as quick as possible. Hope that day comes soon so that many families can have a peaceful existence. Thank you all for opening up and to share your joy and sorrow along with me.

I am greatly indebted to **Dr. Latha Venkatesan, M.Sc. (N)., M.Phil., Ph.D.,** Principal, Apollo College of Nursing, who has been a source of unflagging and whole hearted support. She gave me the opportunity and leading me into the challenging field of substance abuse. She ingrained in me the thought that obstacles exist and thus challenge one to keep going.

I extend my earnest gratitude to **Prof. Lizy Sonia. A., M.Sc. (N).,** Vice Principal and Course Coordinator, Apollo College of Nursing, for her kind encouragement and support to venture into this project.

I owe a great sense of gratitude to my guide **Prof. Vijayalakshmi. K., M.Sc. (N)., M.A. (Psychology).,** the Head of Psychiatric Nursing Department and Research Coordinator, who was a major guiding and sustaining forces in the completion of this thesis. She believed in me and was constantly there for me, whenever I needed pointers to go forward. Discussions with her have opened up new vistas of th~~ink~~ing to me.

My heartfelt thanks to **Mrs. Sathya Nesa Satchi, M.Sc., (N).,** for her valuable suggestions and guidance. I sincerely thank **Mrs. Anuradha. C., M.Sc., (N),** Associate Professor and **Mrs. Stella Mary. I., M.Sc (N).,** Lecturer, Department of Mental Health Nursing, for their steadfast support, inspiration and enduring mentorship.

I am grateful to the **experts** for validating the tools used in this study and also I would like to extend my gratitude to all the Faculty of Apollo College of Nursing for their valuable inputs into the study.

Special thanks are due to **Mr. Kamalesh, Manager Operations,** Wisdom Hospitals, and **Mr. Bharathan, Managing Director,** Freedom Foundation and Care for providing the facilities to carry out this work. They showed me the way and gave me the freedom to pursue it according to my lights.

A note of thanks to the **Librarians** at Apollo College of Nursing and the Tamil Nadu Dr. M. G. R. Medical University, for their help in providing needed reference materials required.

Words fail to express my gratitude I feel towards my parents **Mr. Sundara murthi. K.** and **Mrs. Nangamani. P. K.,** the guiding lights of my life. Thanking them is like thanking myself, so I leave it unsaid. I am also grateful to **Mr. Sunil. S. Krishnan,** who was more than just a brother, but also a close friend and a confidant.

Last but not least I am deeply indebted to all my classmates **'SPARTANS'**, in appreciation of their care and support. The list of individuals who have helped in the entire process of this academic pursuit is far too long and perforce. Hence I limit myself to those whose help can be acknowledged in a tangible way.

SYNOPSIS

Statement of the Problem

A Quasi Experimental Study to Assess the Effectiveness of Assertiveness Training on Assertiveness Skills and Self-Esteem among Alcoholic Patients in Selected De-Addiction Centers at Chennai.

Objectives of the Study

1. To assess the level of assertiveness skills and self-esteem in the control and experimental group of alcoholic patients.
2. To evaluate the effectiveness of assertiveness training by comparing the assertiveness skills and self-esteem of control and experimental group of alcoholic patients before and after the assertiveness training.
3. To find out the association between the selected demographic variables and level of assertiveness skills and self esteem, before and after assertiveness training in the control and experimental group of alcoholic patients.
4. To find out the association between the selected clinical variables and level of assertiveness skills and self-esteem, before and after assertiveness training in the control and experimental group of alcoholic patients.
5. To determine the level of satisfaction among experimental group of alcoholic patients on assertiveness training.

The conceptual framework of the study was based on “Peplau’s Interpersonal Model” (1952). The study variables were assertiveness skills, self-esteem and

assertiveness training. Hypotheses were formulated. The level of significance selected was $p<0.05$. An extensive review of literature and guidance by experts formed the foundation to the development of study instruments. A quasi experimental research design was selected to achieve the objectives of the study. The study was conducted at Freedom care and foundation, Sithalapakkam and Wisdom hospitals, Saidapet. The sample size of the study was 60 (30 in each group). The settings were randomised and allotted to the control and experimental group. Purposive sampling technique was used to select the samples from the respective settings.

The instruments used in the study were demographic variable proforma of alcoholic patients, clinical variable proforma of alcoholic patients, Rathus assertiveness schedule, Rosenberg self-esteem scale. The data collection tools were validated and the reliability was established through split half technique. After the pilot study, the data for the main study was collected by self-administration and interview method. Assertiveness training includes activities like practice sessions with detailed exercises, worksheets, video shows, games and innovative methods with lecture cum discussion using power point presentation. It was a one hour session for a period of ten days. Assertiveness training was administered only to the experimental group. On the 15^{th} day, assertiveness skills and self-esteem scores were assessed for both the control and experimental group by using the Rathus assertiveness schedule and Rosenberg's self-esteem scale. The level of satisfaction on administration of assertiveness training was assessed by using the rating scale in the experimental group. Then collected data were tabulated and analysed using descriptive (frequency, percentage, mean, standard deviation) and inferential statistics (t-test and chi square test).

Major findings of the study

- In the present study, a significant percentage of the alcoholic patients were in the age group of 20-30 years (30%, 53.33%), were graduates (46.67%, 36.67%), were labourers (26.67%, 43.33%), earned a monthly family income of ≤ 10,000 rupees (36.67%, 53.33%), had two children (46.15%, 43.75%), belonged to joint family (43.33%, 50%), had a family history of alcohol abuse/ dependence (63.33%, 66.67%) in the control and experimental group respectively. Majority of them were Hindus (70%, 86.67%) in the control and experimental group respectively. Most of them were unmarried in the control group (53.13%) and married in the experimental group (66.67%) respectively.

- In the present study most of the alcoholic patients in the control and experimental group started consuming alcohol at the age of ≤ 20 years (50%, 56.67%), for a duration of ≤ 10 years (46.67%, 36.67%), stated enjoyment/ pleasure as the precipitating factor for alcohol consumption (73.33%, 66.67%), tolerance as the situation that provoked them to consume more amount of alcohol (63.33%, 63.33%), consumed alcohol everyday (57%, 60%), had tremors in hands and fingers (60%, 66.67%), had a previous history of alcohol de-addiction treatment (73.33%, 70%), believed in alcohol de-addiction treatment to be effective (83.33%, 73.33%) and stated family responsibility as the motivation to seek treatment (73.33%, 60%) respectively.

- Majority of them made an effort to quit or cut down alcohol in the past (93.33%, 76.67) and were abstinent (100%, 100%) at least once for a brief period in the control

and experimental group respectively. A significant percentage of them consumed an amount of ≤ 250 ml per day (30%, 30%), spent an amount of ≤ 250 rupees (50%, 50%), developed complications like depression (26.67%, 40%), stated self-control as the reason for abstinence (21.43%, 17.39%), stated loss of pleasure as the reason for restarting alcohol consumption after a period of abstinence (39.29%, 60.87%), had a history of psychiatric hospitalisation (33.33%, 23.33%) and stated depression as the reason for psychiatric hospitalisation (30%, 57.14) in the control and experimental group respectively.

- Majority of the alcoholic patients in the control group were non-assertive and had normal level of self-esteem before (96.7%, 70%) and after (96.67%, 80%) AST respectively. None of them had high self-esteem. In the experimental group, most of the alcoholic patients were non-assertive and had normal level of self-esteem before AST (93.3%, 70%). However, after the administration of AST, most of them were assertive (63.3%) and majority of them had normal level of self-esteem (76.67%) in the experimental group of alcoholic patients respectively. Twenty percent of them had high self- esteem after AST. This can be ascribed to the effectiveness of AST.

- The mean and standard deviation for scores of assertiveness skills (M=-2.47, SD=12.78), (M=-3.30, SD=12.25) and self-esteem (M=16.93, SD=3.52), (M=15.7, SD=4.25) among alcoholic patients before AST in the control and experimental group was not significant at $p>0.05$. On the other hand, after the administration of AST, the mean and standard deviation of assertiveness skills (M=2.60, SD=13.34) and self-esteem (M=17.37, SD=3.06) of control group were less in comparison with the assertiveness skills (M=24.83, SD=9.56) and self-esteem

(M=21.9, SD=3.54) scores of experimental group. The difference was found statistically significant at $p<0.001$ level of confidence and it can be accredited to the effectiveness of AST. Hence the null hypothesis Ho_1 was rejected.

- There was a significant association between age of the alcoholic patients ($\chi^2 = 4.85$, df=1) at $p<0.05$ and the level of assertiveness skills. In this regard, the null hypothesis Ho_2 was rejected. However, there was no association between other demographic variables such as educational status, occupation, marital status, monthly family income, religion, type of the family, family history of alcohol abuse/ dependence and the level of assertiveness skills ($p > 0.05$). Hence the null hypothesis Ho_2 was retained.

- Majority of the clients (93.33%) were highly satisfied with all the aspects of assertiveness training.

- There was no significant association between any of the selected demographic variables and the level of self-esteem in the control and experimental group of alcoholic patients. Hence the null hypothesis Ho_3 was retained.

- There was no significant association between any of the selected clinical variables and the level of assertiveness skills in the control and experimental group of alcoholic patients. Hence the null hypothesis Ho_4 was retained.

- There was a significant association between duration of alcohol dependence ($\chi^2= 6.49$, df=1; $\chi^2=4.48$, df=1) and self-esteem at $p<0.05$. Hence the null hypothesis

Ho_5 with regard to association between duration of alcohol dependence was rejected.

- However there is no significant association between other clinical variables like age at which the alcohol consumption was started, frequency, amount of alcohol consumption, money spent on alcohol consumption, efforts to quit alcohol in the past, previous history of alcohol de-addiction treatment, belief in effectiveness of de-addiction treatment, history of psychiatric hospitalisation and the level of self-esteem ($p > 0.05$). In this regard, the null hypothesis Ho_5 with regard to association between the other selected clinical variables such as age at which the alcohol consumption was started, frequency, amount of alcohol consumption, money spent on alcohol consumption, efforts to quit alcohol in the past, previous history of alcohol de-addiction treatment, belief in effectiveness of de-addiction treatment, history of psychiatric hospitalisation and self-esteem was retained.

Recommendations

- The study can be conducted on a large scale to generalize the results.
- The study can be conducted among different groups like adolescents, mentally ill patients, teenagers who abuse other substances, family members of alcoholic patients etc.
- A follow up study can be conducted to assess the effectiveness of the present programme in reducing the relapse rates of alcoholic patients.
- A time series design can be conducted with an interval of 2, 4 and 6 months to assess the long term effects of assertiveness training upon assertiveness skills and self-esteem.
- A study can be conducted on quality of life among alcoholic patients.

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CHAPTER- I

INTRODUCTION

Background of the Study

"It is better to be hated for what you are,

Than to be loved for something you are not"

-Andre Gide

Alcoholism is a disorder characterised by loss of control over drinking, with habituation to the drug alcohol, causing interference in any major life function. e.g. health, family, job, spiritual, friends, legal.

The world's highest alcohol consumption levels are found in the developed world, including Western and Eastern Europe. According to the Hindustan Times it is estimated that around 1% of the population in India, can be classified as being alcohol-dependant. This translates into about 5 million people dependant on alcohol. Kerala is the largest consumer of alcohol in India, followed by Punjab. Kerala alone accounts for 16% and Punjab accounts for 14% of all the liquor consumed in India.

Alcoholism is multifactorial in nature. The causes of alcoholism are bio-socio-psycho-faceted. Experts in the medical field ascribe alcohol problems and alcoholism to a bewildering array of causes. Genetic or bio-chemical predisposition to alcoholism is a controversy that has been debated for years. Conflictual emotions, irrational cognitions, social learning processes, family pathology, sociocultural influences, self regulation failure and personal choice are also considered as contributory factors.

The damage of long term alcohol consumption on the health of an individual is well documented. According to Global status report on alcohol and health of WHO, 2011, the harmful use of alcohol results in approximately 2.5 million deaths each year

which is greater than deaths caused by HIV/AIDS, violence or tuberculosis. Alcohol ranks eighth among global risk factors for death, third for disease and disability. It is a causal factor in 60 types of diseases and injuries and a component cause in 200 others.

It is estimated to cause from 20% to 50% of cirrhosis of the liver, epilepsy, poisonings, road traffic accidents, violence and several types of cancer. New evidence points to a causal link between alcohol and infectious diseases. A strong association is found to exist between alcohol consumption and sexually transmitted diseases like HIV infection. Alcoholism is also associated with many serious social issues, including violence, child neglect and abuse, and absenteeism in the workplace. Perhaps the biggest social impact is crime and violence related to alcohol consumption, which create significant costs for justice and law enforcement sectors.

It has become increasingly evident that legal sanctions and moral pressures have not provided an adequate remedy for this problem. Moreover, it is estimated that treatment of alcoholic individuals with present techniques would fill every existing hospital bed and require the full-time services of every physician in the Nation. Consequently, solution of this problem must ultimately lie in the development of improved prevention and treatment techniques.

Treatment of alcoholism takes several steps. Accepting that one has a problem, and seeking help when necessary, is the first step to quit alcohol. Because of the medical problems that can be caused by withdrawal, alcohol detoxification is carefully controlled and may involve medications such as benzodiazepines. Some are assisted by counselling from a nurse, doctor or specially trained counsellor. In some cases, cognitive behavioural therapy and motivational interviewing may be appropriate. Many programs also offer marital counselling and family therapy as part of the treatment process. Virtually all alcoholism treatment programs also include meetings of

Alcoholics Anonymous, which describes itself as a "worldwide fellowship of men and women who help each other to stay sober."

Humans are emotional creatures, and this emotion often gets them into trouble. When one has to deal with people on a personal level, it is always critical to keep the emotions in check. “Being firm without being rude”, is the art of assertiveness. It is the action of declaring oneself, or stating, "This is who I am and what I think and feel". Alberti and Emmons (1970), perhaps summarized it best when they said that assertive behaviour is that "which enables a person to act in his own best interest, to stand up for himself without undue anxiety, to express his rights without denying the rights of others". They assume the best about people, respect themselves, think “win-win” and try to compromise. As we become more assertive, we drop the mask and show our true selves. An assertive manner certainly means that we'll feel more empowered, and more in control of circumstances.

One of the main reasons people have a hard time being assertive is that they have a low self-esteem. They do not express their thoughts, feelings and needs for fear of rejection, or are afraid that people won’t like them any longer if they don’t help with whatever is requested of them. As quoted by Butler (1979), “Being able to assert oneself is a necessary ingredient of becoming self- actualised and to developing and maintaining self-esteem”. This process gives power over us and our destinies.

A behaviour that is frequently attributed to alcoholics involves a pattern of inappropriate responding to inter-personal conflict situations. Rather than dealing with such situations in a forth-right assertive fashion, alcoholics choose avoidance or passive-aggressive manoeuvres. Most obvious of these inappropriate responses is excessive drinking, which may involve aspects of avoidance, passive- aggressiveness and a variety of ineffective responses to inter-personal conflicts.

Assertiveness training is required for patients who in interpersonal contexts have unadaptive anxiety responses that prevent them from saying or doing what is reasonable and right. It is assumed that, assertive behaviour will bring about positive changes in the behaviour of others toward him, and thus be better able to achieve significant social (as well as material) rewards. Therefore, the individual achieves both internal and external positive feedback from appropriate assertive responses.

Clients, who benefit from assertiveness training, often state that they have become less inhibited, more outspoken, and able to stand up for their rights. Clinicians have recognized that assertive training can be effectively utilized to help alcoholic clients achieve a greater degree of self-esteem and emotional freedom. Hence, the present study was an attempt to fulfil these goals by developing an all-inclusive assertiveness training program and evaluating its usefulness among alcoholic patients.

The role of nursing involves interaction with clients, peers and other health professionals. This role is enhanced when nurses have a good command of communication skills. An essential component of effective communication is the ability to behave assertively. Thus nurses while interacting with alcoholic patients can incorporate formal and informal training on assertiveness to promote assertiveness skills and self-esteem so as to improve the coping skills and quality of life of alcoholic patients.

Need for the Study

Alcoholism is a broad term for problems with alcohol, and is generally used to mean compulsive and uncontrolled consumption of alcoholic beverages, usually to the detriment of the drinker's health, personal relationships, and social standing. High-income countries generally have the highest alcohol consumption. Every

fifth death is due to harmful drinking in the Commonwealth of Independent States. Mohan, Chopra, Ray & Sethi (2001), conducted a survey in three districts (central, north and north-east India), and reported a prevalence of current alcohol use of 20–38% in males and of 10% among females.

Studies in Northern India found the 1 year prevalence of alcohol use to be between 25 and 40% (Varma, Singh, Singh & Malhotra et al., 1980). In Southern India, the prevalence of current alcohol use varies between 33 and 50%, with a higher prevalence among the lesser educated and the poor (Chakravarthy et al., 1990). A number of factors have been implicated in the predisposition to abuse of alcohol. At present there is no single theory that can adequately explain the aetiology of this problem. No doubt the interaction between various elements forms a complex collection of determinants that influence a person's susceptibility to abuse substances like genetics, biochemical, psychological and sociocultural factors.

Alcohol can induce a general, non-selective, reversible depression of the CNS. Only moments after alcohol is consumed, it can be found in all tissues, organs and secretions of the body. At low doses alcohol produces relaxation, loss of inhibitions, lack of concentration, drowsiness, slurred speech and sleep. Chronic abuse results in multisystem physiological impairments. These complications include cirrhosis of the liver, pancreatitis, epilepsy, polyneuropathy, alcoholic dementia, heart disease, nutritional deficiencies, peptic ulcers and sexual dysfunction, and can eventually be fatal.

Treatment can be broadly divided into two categories, which are often interlinked. These are detoxification and treatment of alcohol dependence. Detoxification is the treatment of alcohol withdrawal symptoms. After detoxification, there are several methods to choose from like behaviour therapy, psychotherapy, group

therapy and other deterrent agents like disulfiram for further management. Among these assertiveness training is one of important psychosocial interventions for the alcoholic patients.

The therapeutic objective of assertiveness training with alcoholics is to provide clients with direct training in precisely those interpersonal and social skills deficient. Very little attention is given to eliminate existing maladaptive behaviour; instead, as skilful, adaptive responses are acquired, rehearsed and reinforced, the previous maladaptive responses will be displaced and will disappear. Assertiveness training is very similar to deep muscle relaxation in being physiologically antagonistic to anxiety. It will instill in the client a greater feeling of well-being. It will also help them to express their needs in a forthright straight forward assertive manner. As positive rewarding behaviours are practiced and developed, they will compete with and eventually replace alcoholic avoidance and escape.

The literature indicates that alcoholic patients experience problems related to being non-assertive. Thus there is a need to develop a comprehensive program to train the alcoholic patients in assertiveness and related skills. However within the Indian context, research has not focussed on assertiveness and formulation of specific strategies in order to deal with the non-assertive behaviour of alcoholic patients.

Thus this study was undertaken to assess the effectiveness of assertiveness training on assertiveness skills and self-esteem among alcoholic patients. This will help the nurses to plan for the assertiveness training as a part of routine care of alcoholic patients. This will improve the assertiveness and self-esteem level of patients which in turn would help them to adopt healthy coping strategies rather than depending on alcohol. It would prevent relapse and remain abstinent from alcohol intake in future, after the course of de-addiction treatment.

Statement of the Problem

A Quasi Experimental Study to Assess the Effectiveness of Assertiveness Training upon Assertiveness Skills and Self-Esteem among Alcoholic Patients in Selected De-Addiction Centers at Chennai.

Objectives of the Study

1. To assess the level of assertiveness skills and self-esteem in the control and experimental group of alcoholic patients.

2. To evaluate the effectiveness of assertiveness training by comparing the assertiveness skills and self-esteem of control and experimental group of alcoholic patients before and after the assertiveness training.

3. To determine the level of satisfaction among experimental group of alcoholic patients on assertiveness training.

4. To find out the association between the selected demographic variables and level of assertiveness skills and self esteem, before and after assertiveness training in the control and experimental group of alcoholic patients.

5. To find out the association between the selected clinical variables and level of assertiveness skills and self-esteem, before and after assertiveness training in the control and experimental group of alcoholic patients.

Operational Definitions

Effectiveness

In this study, it refers to the extent to which assertiveness training has improved the level of assertiveness skills and self–esteem in terms of increase in assertiveness skills and self-esteem scores among the alcoholic patients.

Assertiveness training (AST)

In this study, it is a planned one hour interventional program for a period of ten days by using pre-designed module. Assertiveness training includes various components such as modelling, coaching, role playing, instructions, behaviour rehearsal, feedback and graded-structured exercises. Techniques like fogging, broken–record and negative assertion were employed. Activities like practice sessions with detailed exercises, worksheets, video shows, games and innovative methods with lecture cum discussion using power point presentation were held.

Assertiveness skills

In this study, it refers to standing up for one's rights without infringing the rights of others, which includes components like interpersonal communication, self concept and public speaking as measured by the Rathus assertiveness schedule.

Self – esteem

In this study, it refers to the over-all evaluation of his/her own worth as measured by Rosenberg's self- esteem scale.

Alcoholic patients

In this study, it refers to patients who are dependant /abuse alcohol and is currently undergoing treatment in de-addiction centre.

De-addiction centres

In this study, it is a legally registered organisation which provides treatment and rehabilitation services to patients who abuse substance.

Assumptions

The study assumes that:

- Man is a social animal who cannot live in isolation.
- Dependence causes progressive neglect of alternative interests because of alcohol use.
- Alcoholics suffer a disturbed and stressful life situation in relationship to their personality and family atmosphere.
- The family members of alcoholics experience agony, ambivalence and frustration because of the problems arisen due to alcoholism.
- An assertive individual will be able to resist peer pressure to drink.
- People who have mastered the skill of assertiveness are able to greatly reduce the level of interpersonal conflict in their lives.
- Every human being has a right to live with self-esteem.
- The self- esteem an essential quality to reduce anxiety may be lost to alcoholics.
- Low self-esteem can result in depression.
- Assertiveness training is a psycho social intervention.
- Some strategies are required to combat the menace of alcoholism.

Null Hypotheses

Ho_1: There will be no significant difference in assertiveness skills and self-esteem before and after assertiveness training in the control and experimental group of alcoholic patients.

Ho_2: There will be no significant association between the selected demographic variables and the level of assertiveness skills before and after assertiveness training in the control and experimental group of alcoholic patients.

Ho_3: There will be no significant association between the selected demographic variables and the level of self-esteem before and after assertiveness training in the control and experimental group of alcoholic patients.

Ho_4: There will be no significant association between the selected clinical variables and the level of assertiveness skills before and after assertiveness training in the control and experimental group of alcoholic patients.

Ho_5: There will be no significant association between the selected clinical variables and the level of self-esteem before and after assertiveness training in the control and experimental group of alcoholic patients.

Delimitations

- Study period was limited to 4 weeks only.
- Study participants were confined to alcoholic patients who attend selected de-addiction centres.

Conceptual Framework of the Study

The conceptual framework deals with the inter-related concepts that are assembled together in some rational schemes by virtue of their relevance to a common theme (Polit and Beck, 2010). The conceptual framework of the study is based on “Peplau’s Interpersonal Model” (1952). According to Hildegard Peplau, "the goals of nursing are currently in transition; its major concern fifty years ago had to do with getting sick people well; today, nursing is more concerned with ways for helping people to stay well".

The model views nursing in two ways. Firstly, nursing is educative. Secondly, nursing is therapeutic. With these two functions combined, they allow nurses and clients to develop skills for problem solving. This process of education and therapeutic interaction occurs only within the relationship of the nurse and the client. This interpersonal relationship between the nurse investigator and the alcoholic patients has four clearly discernible phases. These phases are orientation, identification, exploitation and resolution. Each of these phases are seen as being interlocking and requiring overlapping roles and functions as the nurse and the alcoholic patients learn to work together to resolve difficulties in relation to health problems.

Orientation

The alcoholic patients and nurse investigator came together as strangers meeting for the first time. During this phase, the development of trust and empowerment of the alcoholic patients were primary considerations. The nurse investigator encouraged the alcoholic patients to participate in identifying the need for assertiveness and allowed them to be an active participant in assertiveness training program. By asking for and receiving help, the alcoholic patients felt more at ease expressing their need for assertiveness knowing that the nurse investigator will take care of those needs. Once orientation has been accomplished, the relationship entered the next phase.

Identification

The alcoholic patients in partnership with the nurse investigator were able to identify the problems of unassertiveness and low self-esteem that require working on within the relationship. The alcoholic patients selectively responded to a nurse investigator who offered the assertiveness training program needed by the alcoholic patients. Both the nurse investigator and the alcoholic patients clarified each other's perceptions and expectations, which affected the ability of both to identify problems and the necessary solutions. When clarity of perceptions and expectations was achieved, the alcoholic patients learned to make use of the nurse investigator- patient relationship. Once identification has occurred, the relationship entered the next phase.

Exploitation

The alcoholic patients took full advantage of assertiveness training program. The degree to which the assertiveness training program was used is based upon the needs and the interest of the alcoholic patients. Within this phase, alcoholic patients began to develop assertiveness skills and self-esteem. They started to take control of their life situation with the assertiveness training program that was offered. From this sense of self-determination, alcoholic patients developed an inner strength that allowed them to face new challenges. As the relationship passed through all of the aforementioned phases and the needs of the alcoholic patients have been met, the relationship passed to closure or the phase of resolution.

Resolution

It occurred when the needs of assertive skills and self-esteem was met. It implied the gradual freeing from identification with the nurse investigator and the generation and strengthening of ability to stand more or less alone.

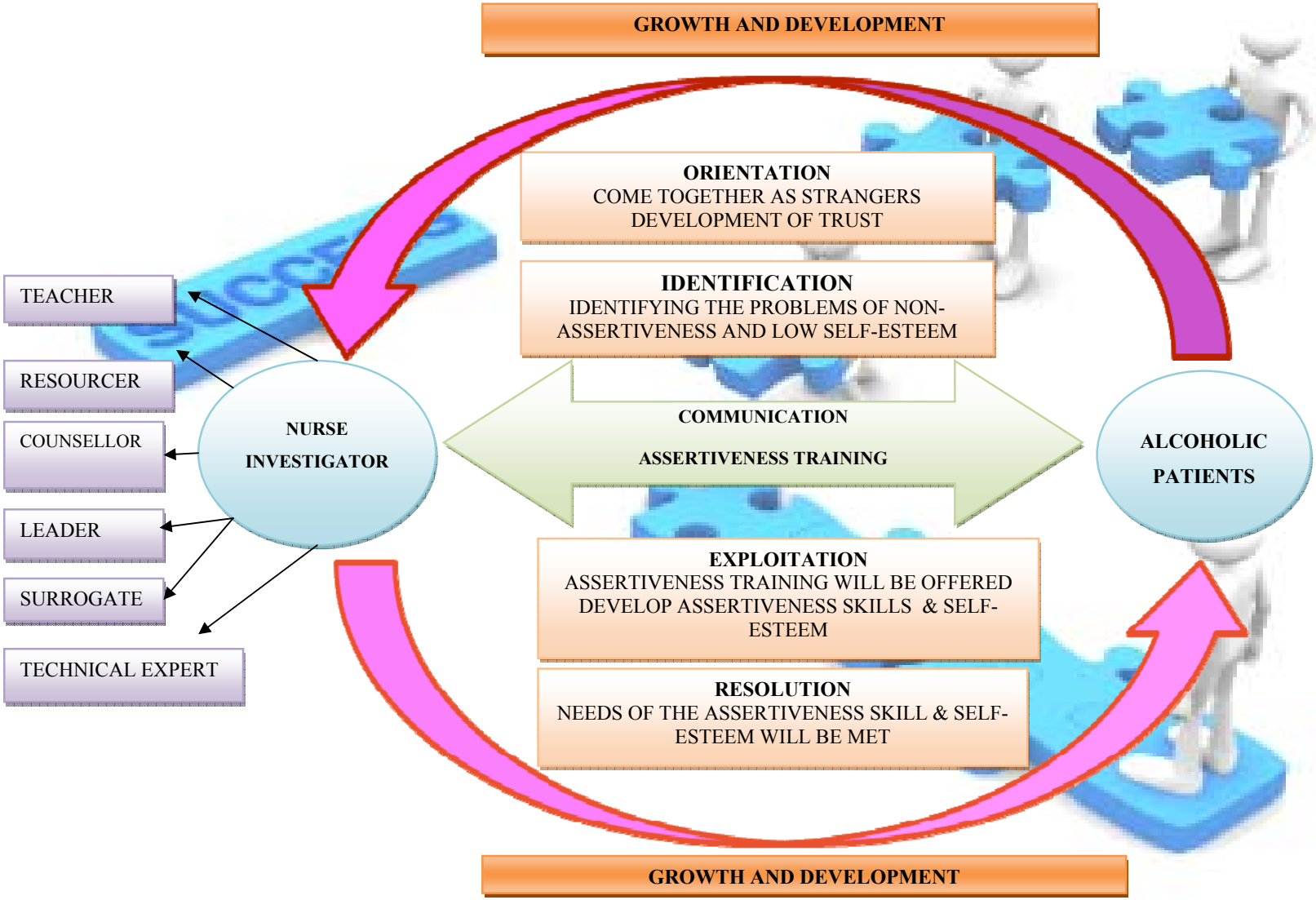

Fig 1: Conceptual Framework on Assertiveness Training based on Peplau's Interpersonal Model

Projected Outcome

This study will be useful to enhance the assertiveness skills and self-esteem of alcoholic patients. In turn, it will help them to express their views in a clear, affirmative way without stepping on others toes. It will help in building an effective communication pattern which will indirectly influence the prognosis and reduce the relapse rate.

Summary

This chapter has dealt with the background, need for the study, and statement of the problem, objectives, operational definitions, assumptions, null hypotheses, delimitations and conceptual framework.

Organisation of the Report

Further aspects of the study are presented in the following five chapters.

In Chapter – II : Review of literature.

In Chapter – III : Research methodology- which includes research approach, design, setting, population, sample and sampling techniques, tool description, content validity and reliability of tools, pilot study, data collection procedure and plan for data analysis.

In Chapter – IV : Analysis and interpretation of data.

In Chapter – V : Discussion.

In Chapter – VI : Summary, conclusion, implications and recommendations.

CHAPTER - II

REVIEW OF LITERATURE

"Review of literature is a key step in the research process. It is an extensive systematic scrutinisation of potential sources of previous study and work. The typical purposes of it are to generate research questions, to identify what is known and not known about the topic and to describe methods of enquiry used in earlier work including their success and short comings".

Assertiveness is a concept which in recent years has gained immense recognition in our society (Alberti & Emmons, 1982). The majority of the articles on assertiveness in nursing journals have been of the "how- I-ran-an-assertiveness-training-class" kind or of the general "assertiveness-can-help-reach-one's-potential' variety (Donner & Goering, 1982).

This chapter is an attempt to review studies on the related aspects of assertiveness, self-esteem and alcoholism. The research studies that have explored the above mentioned areas has been organised under the following sections;

- Literature related to alcoholism.
- Literature related to assertiveness skills of alcoholic patients.
- Literature related to self-esteem of alcoholic patients.
- Literature related to effectiveness of assertiveness training.

I. Literature related to alcoholism

According to the Global status report on alcohol and health, the world's highest alcohol consumption levels are found in the developed world, including Western and Eastern Europe. High-income countries generally have the highest alcohol consumption. Every fifth death is due to harmful drinking in the Commonwealth of Independent States. Outside of the Russian Federation and some neighbouring countries, rates of disease and disability attributable to alcohol are also quite high, for example, in Mexico and in most South American countries (WHO, 2011).

In 2002, a study was conducted to examine the pattern of drinking in India. The results found out that, there are 62.5 million estimated alcohol users in India whose per capita consumption increased by 106.7% over the estimated 15 year period from 1970 to 1996. The study results also showed that alcoholism has nothing to do with age, education, intelligence or socio-economic status (Parry & Charles, 2002). Mohan, Chopra, Ray & Sethi (2001), conducted a survey in three districts (central, north and north-east India), which involved 32,000 people and used standardized questionnaires based on DSM III. The objective of the study was to report the prevalence of alcohol use among males and females. The results revealed prevalence of current alcohol use of 20–38% in males and of 10% among females.

In Southern India, a study was conducted to associate socioeconomic correlates with that of alcohol use. The results found out that the prevalence of current alcohol use varies between 33 and 50%, with a higher prevalence among the lesser educated and the poor (Chakravarthy et al., 1990). In 1980, study examined 1 year prevalence of alcohol use among 500 samples in Kolkata. Results showed that the 1 year prevalence of alcohol use to be between 25 and 40% (Varma, Singh, Singh & Malhotra et al., 1980).

II. Literature related to assertiveness skills and alcoholism

Researchers from the University of Virginia gathered information on drug and alcohol use among a diverse group of 150 teenagers. They also examined the teens' social skills and friendships as well as how they communicated with their mothers. The study found the teens that were best able to resist peer pressure were those who openly expressed their views with their mothers. These teens also used reasonable arguments instead of whining or using insults to influence their mother's opinion on common issues, such as grades, household rules, money and chores (Dallas, 2011)

Patock-Peckham, Cheong, Balhorn & Nagoshi in 2006, compared alcoholic and non-alcoholic psychiatric patients on self-reported assertiveness and behavioural assertiveness. Here, the relationship between the assertiveness of alcoholics and their alcohol drinking behaviour was assessed. Results indicated that, while alcoholics reported themselves to be more assertive than non-alcoholic's, both groups were equally non-assertive on behavioural tests measuring negative assertion which is expression of anger or irritation.

In 2002, Zielenski et al., administered assertive situations varying in social-interpersonal context to depressed alcoholic patients by means of role playing in Michigan. Results showed that assertive behaviours varied as a function of sex and social context providing further support for a stimulus-specific theory of assertiveness. Suggestions were made for the assessment and treatment of assertive skill deficits within comprehensive treatment programs for alcoholism.

A study examined the relationships among risk taking, refusal assertiveness, and alcohol use in a sample of 1,459 inner-city minority students using a cross-lagged longitudinal structural equation model. High risk takers reported less frequent

subsequent refusal assertiveness which predicted an increased alcohol use. These findings suggested that alcohol prevention programs that focused on enhancing competence or reducing normative expectations for peer alcohol use might be more effective for high risk-taking youth (Epstein et al., 1981).

In 1979, a study compared two groups of alcoholics who were markedly different in terms of assertiveness by a self-report measure. Results revealed that alcoholics who were low in assertiveness showed more neurotic and psychotic characteristics on the MMPI; were high on general anxiety, more depressed and had low level of energy when compared to the highly assertive alcoholics (Sturgis & Calhoun).

Eisler, Miller & Hersen (1973), studied components of assertive behaviour. Those who were perceived as being assertive tend to respond to interpersonal problems quickly, in a strongly audible voice with a marked intonation. The results obtained showed that highly assertive individual do not automatically accede to the demands of others and are more likely to request the others to have a change in their behaviour. In Peru, a study conducted using multivariate grouping techniques on MMPI data identified four distinct personality profiles among an alcoholic sample. The most prominent feature of one of these profiles was poorly controlled anger, and another profile was related to a tendency to be in a dependant marital relationship with a dominant partner. Both of these profiles suggest ineffective and possibly non-assertive interpersonal stances (Goldstein, Steven, Linden & James et al., 1969).

III. Literature related to self-esteem and alcoholism

In the Oxford University a study was conducted with an objective of relating teenagers' alcohol use and their level of self-esteem among a sample of 158 college students. It was found that teenagers who experimented with alcohol usually can maintain a healthy sense of self. On the other hand teenagers who make alcohol their primary entertainment and all they do is drink, usually have lower self esteem (Debra, 2011).

Silverstone et al., carried out a study to determine the prevalence and degree of low self-esteem across the spectrum of psychiatric disorders on a consecutive sample of 1,190 individuals attending an open-access psychiatric outpatient clinic. The results of the study demonstrated that all psychiatric patients suffer from some degree of lowered self-esteem. Furthermore, self-esteem was lowest in patients with major depressive disorder, eating disorder, and substance abuse (2003).

In Virginia a study was conducted among a total of 1520 children, 9 to 10 years of age, whose self-esteem was measured using self-perception profile for children. Additional data included a self-administered questionnaire at 13 to 14 years of age concerning emotional well being, smoking, and alcohol consumption. It was found that obese children with decreasing levels of self-esteem demonstrated significantly higher rates of sadness, loneliness, and nervousness and was more likely to engage in high-risk behaviours such as smoking or consuming alcohol (Strauss et al., 2000).

Greenberga et al., (1999) examined whether there is a tendency for individuals to be multiply addicted, overlapping addictions to common substances (alcohol, caffeine, chocolate, cigarettes) and activities (exercise, gambling, internet use, television, video games) in 129 college men and women. The results found out that self-esteem was positively related to exercise but unrelated to the remaining addictions.

A study was carried out in Pittsburgh to provide a comprehensive description of the clinical features of patients who presented to an intake psychiatric setting which concluded that the depressed alcoholics differed significantly from the non-alcoholic depressed patients on only two depressive symptoms, suicidality (59% higher) and low self-esteem (22% higher) (Cornelius et al., 1995).

Hull et al., (1983) tested the proposition that alcohol is consumed as a function of the quality of past performances and of the individual's level of private self-consciousness. 120 adult male study samples were randomly given success or failure feedback on an intellectual task. They then participated in a separate "wine-tasting" experiment in which they were allowed to regulate alcohol consumption. As predicted, high self-conscious study samples who had received failure feedback drank significantly more than did high self-conscious study samples who received success feedback.

In 1976, Gossop et al., investigated the association between self-esteem and drug dependence among 71 subjects who completed semantic differential forms for their self and ideal-self concepts. Results showed considerable deficiencies of self-esteem among drug-dependent patients, and that female addicts are especially deficient in this respect. It was suggested that self-image therapy may be of value for certain drug-dependent patients, especially females.

IV. Literature related to effectiveness of assertiveness training

Hester et al., (2003) performed a meta-analysis ranking all current alcoholism treatments. They rated only those studies that had randomly assigned alcoholics to at least one comparison group in addition to the treatment being evaluated. A total of 219 studies met the criteria. Forty-three treatments were ranked, although 13 of them had

too few studies to be definitively rated. Brief interventions had the highest score, followed by social skills training. At the bottom of the list in effectiveness were general alcoholism counselling and educational lectures and films about alcoholism. AA received the lowest score among the 13 treatments inadequately tested.

Pfost et al., (1992) examined three outcomes of assertion training considered relevant for alcoholics: (a) assertive behaviour in negative situations; (b) discomfort in negative situations that call for assertive behaviour and (c) expectations of assertive behaviour in sober vs. intoxicated states. Subjects were 38 male alcoholics in an inpatient treatment program. Although some behavioural competencies were acquired after assertion training, such training did not differentially reduce discomfort in negative situations or the discrepancy between perceptions of assertiveness in sober vs. intoxicated states at post-test or at 6-week follow-up.

A study was conducted with two different forms of assertiveness training program designed for use in an inpatient ward at a VA hospital. Alcoholic subjects were pretested on self-report, behavioural and unobtrusive measures of assertiveness, and randomly assigned to one of three conditions: rehearsal group, modelling group, or discussion control group. Six 1-hour group assertiveness training sessions were held over a 2-week period. On completion of the assertiveness training, trained subjects scored significantly higher on the measures of assertiveness than did controls; and received more regular (vs. irregular) discharges from the hospital. At a 2-month follow-up interview from date of discharge, assertiveness trained subjects reported less drinking and more abstinent days than controls, though the differences were not statistically significant (Nelson & Howell, 1982).

Of 101 alcoholic subjects participating in an intensive three week program, 56 received assertion training and 45 did not. All subjects were asked to take part in a

one year follow-up program, during which data were collected on drinking behaviour, work performance, job retention, and psychological functioning. Subjects who received assertion training achieved better results on all 4 outcome measures. While several recent studies have suggested that specific treatment procedures have little effect on outcome, this study indicates that assertion training in a comprehensive program significantly improves outcome (Freedberg et al., 1981).

A study was conducted to delineate the parameters of unassertiveness in alcoholics as compared to normals. A random sample of 123 state hospitalised alcoholics was chosen as a standardisation / normalisation group for the Rathus assertiveness schedule. The results of the study found that alcoholics who received 10 hours of assertiveness training scored significantly higher than control and minimal training groups on three measures of assertiveness (Hirsch, Rosenberg, Phelan & Dudle, 1978). Adinolfi, McCourt & Geoghega (1976), conducted a study among six men alcoholics in Copenhagen to evaluate the effectiveness of assertiveness training among alcoholics. The results showed an increase in assertiveness and improvement in social and occupational status after attending a group assertiveness training program.

Even though assertiveness training is very beneficial, there is paucity of research in this area especially among alcoholic patients. Thus the investigator is interested to assess the effectiveness of assertiveness training on self-esteem and assertiveness skills among alcoholic patients.

Summary

This chapter has dealt with the review of literature related to problem stated. It has also enabled the researcher to design the study, develop the tool, and plan the data collection procedure to analyze the data. 25 studies were reviewed. Out of which 21 were retrieved from primary sources and 4 were retrieved from secondary sources.

CHAPTER - III

RESEARCH METHODOLOGY

The present study was conducted to assess the effectiveness of assertiveness training among the alcoholic patients on enhancing the level of assertiveness skills and self-esteem, at selected de-addiction centres.

This chapter deals with the methodology adopted by the investigator for the study. It includes research approach, research design, sample and sampling technique, development of data collection instruments, method of data collection, pilot study and plan for data analysis. On the whole it gives the general process for gathering and processing research data.

Research Approach

Research approach is the most significant part of any research. According to Polit & Beck (2010), Experimental research is an extremely "applied" form of research involving in finding out how well a programme, practice, or policy is working. In this study as the investigator wanted to assess the effectiveness of assertiveness training on the level of assertiveness skills and self-esteem of alcoholic patients, the experimental approach was chosen to conduct this study.

Research Design

A research design incorporates the most important methodological design that a researcher works in conducting a research study (Polit & Beck, 2010). The research design used this study is quasi experimental design. Two settings were chosen for the study. These settings were randomly assigned to the control and experimental group. In

this study, the investigator manipulated the independent variable i.e. assertiveness training which was conducted to the experimental group. The level of assertiveness skills and self-esteem scores was assessed for both the control and the experimental group before and after the intervention. Then the level of satisfaction was assessed using rating scale.

$$O_1 \quad - \quad O_2$$

$$O_1 \quad X \quad O_2$$

O1 Pre test to assess the level of assertiveness skills and self-esteem.

O2 Post test to assess the level of assertiveness skills and self-esteem.

X Assertiveness training.

Intervention

It is a planned one hour interventional program for a period of ten days by using pre-designed module. The researcher utilised all the components of assertiveness training such as modelling, coaching, role playing, instructions, behaviour rehearsal, feedback and graded-structured exercises. Techniques like fogging, broken–record and negative assertion were employed. Activities like practice sessions with detailed exercises, worksheets, video shows, games and innovative methods with lecture cum discussion using power point presentation were held. It mainly focused on assertiveness skills and the core factors of assertiveness. The program was conducted mainly in the mornings between 11 am to 12 pm.

The intervention was designed to help the alcoholic patients handle difficult interpersonal situations by asserting themselves and letting others know what they want through turning down a request, asking a favour, expressing disapproval and giving

someone a compliment. Hence it emphasized both on the task of becoming more self-expressive and retaining good relationships with those around the patient. It also helped to break old, unhealthy patterns of communication and replace them with more powerful and effective ways of thinking, feeling, behaving and relating to others. Ice breaking sessions was also conducted between the sessions to prevent monotony of the program. (These details are given in appendix)

Variables

An abstract concept that can be measured in a study is called a variable. Variables are characteristics that vary among the subject being studied.

Independent variable

The independent variable of the study is assertiveness training.

Dependent variable

It was the level of assertiveness skills and self-esteem among alcoholic patients.

Attribute variable

It included the demographic and the clinical variables which has influence on the assertiveness skills and self-esteem of alcoholic patients.

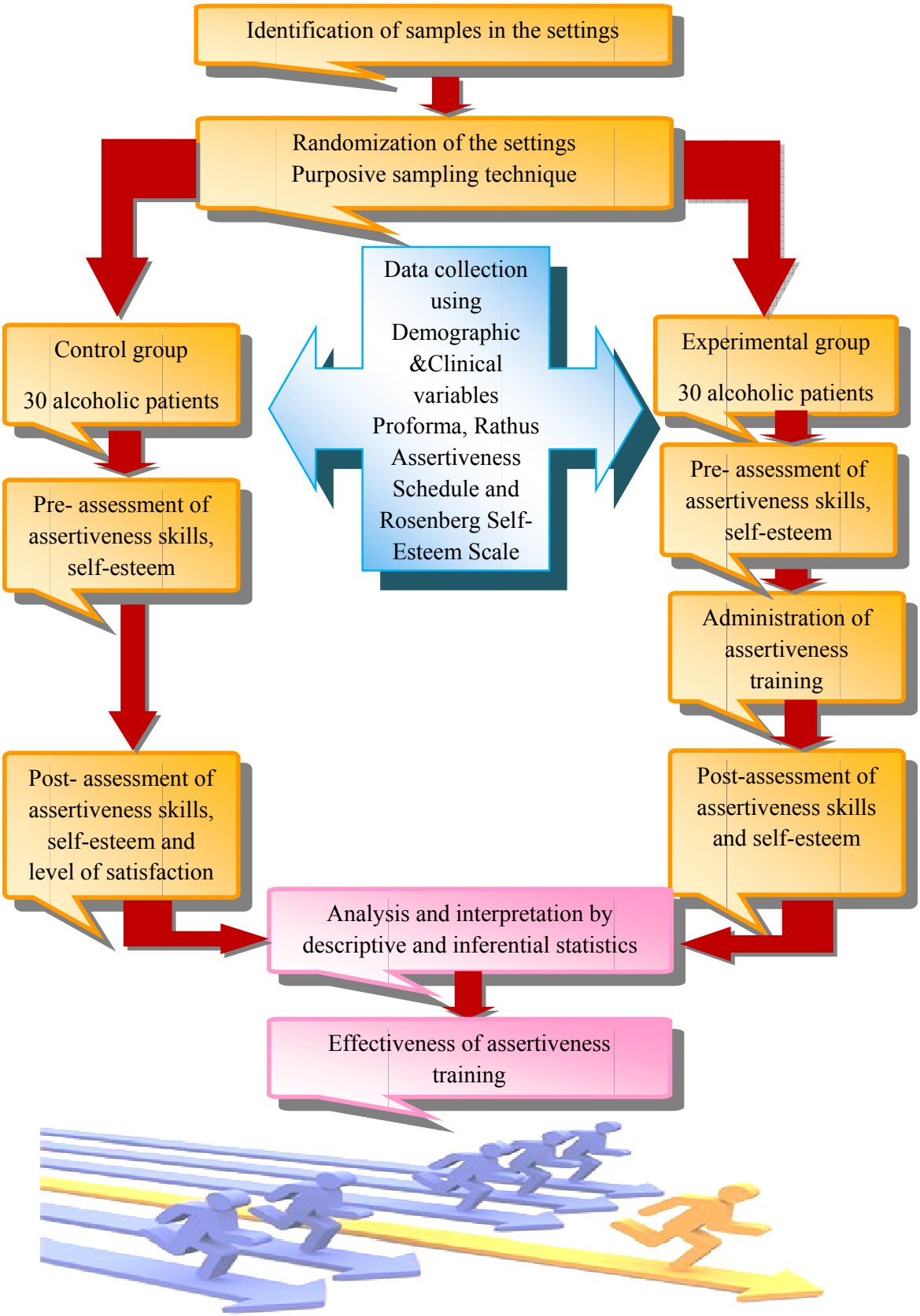

Fig 2: Schematic Design of the Study

Research Settings

The study was conducted at Freedom care and foundation which is situated at Sithalapakkam in Chennai at a distance of 21 kilometres from Koyambedu. The year 1993 saw the materialization of Freedom care and foundation with the commencement of an exclusive facility offering treatment for alcohol and drug dependency. It is a 30 bedded de-addiction cum rehabilitation centre. It offers tailor made programs for men and women who suffer from addiction and are struggling to recover. It continues to grow with various new innovations and scaled up interventions in the area of alcohol and drug abuse. It provides in-patient treatment with boarding and lodging facilities. The treatment and rehabilitation services include medical management (detoxification) and psychological therapy. The primary treatment is followed by after care, follow-up and vocational rehabilitation services.

Wisdom hospitals is located at Saidapet in Chennai at a distance of 8.69 kilometres from the Central Railway Station. Wisdom hospital is a unit of Savitha Charitable Trust, which started functioning in the year 2002 with a vision to lend a helping hand to the suffering addicts. The main activities of Wisdom hospitals are detoxification and rehabilitation of individuals addicted to alcohol, tobacco, narcotics and other drugs. Patients with behavioural problems and psychiatric disturbances are also given treatment. The treatment period can vary according to the individual requirement, though it is a 60 days residential programme for alcoholics and 90 days for drug addicts.

Target Population

Target population is the group of population, that the researcher is aimed to study and to whom the study findings will be generalised. In this study target population will comprise of alcoholic patients.

Accessible Population

Accessible population is the list of population, the researcher finds in the research area. Accessible population in this study is alcoholic patients admitted in Freedom care and foundation and Wisdom hospitals.

Sample

Sample consists of subset of units that comprises the population. A sample of 60 alcoholic patients who met the inclusion criteria, in selected de-addiction centres, Chennai. (30 patients in control group were selected from Freedom care and foundation and 30 patients in experimental group were selected from Wisdom hospitals).

Sampling Technique

It was stated by Polit and Beck (2010) that sampling referred to the process of selecting a portion of the population to represent the entire population. The participants of the present study were selected by purposive sampling technique. It is a non-probability sampling technique in which the researcher selected participants based on the needs of the alcoholic patients.

Sampling Criteria

Inclusion criteria

- Patients who are admitted in alcoholic de-addiction centres.
- Patients who are dependant on alcohol / abuse alcohol.
- Patients who can speak English or Tamil.
- Patients willing to participate in the study.

Exclusion criteria

- Patients with acute or severe psychotic symptoms, severe withdrawal symptoms and unable to co-operate.
- Patients who are not willing to participate.

Selection and Development of Study Instruments

As the study aimed to evaluate the effectiveness of assertiveness training upon assertiveness skills and self-esteem, the data collection instruments were developed and chosen through an extensive review of literature in consultation with experts and with the opinion of faculty members. The instruments used in this study were demographic variables proforma of alcoholic patients, clinical variables proforma of alcoholic patients, Rathus assertiveness schedule, Rosenberg self-esteem scale and rating scale on the level of satisfaction upon assertiveness training among alcoholic patients.

1. Demographic variable proforma of alcoholic patients

Demographic variables proforma of alcoholic patients consists of age, gender, educational status, occupation, marital status, monthly family income, number of children, religion, type of the family, family history of alcohol abuse etc.,

2. Clinical variable proforma of alcoholic patients

This was used to assess the clinical variables of alcoholic patients such as age at which the alcohol consumption was started, precipitating factor, feelings when first consumed alcohol, situations that provoked to consume more amount of alcohol, duration, frequency, form, amount, money spent, history of usage of other addictive agents, associated symptoms, associated complications, problems arisen due to alcohol

consumption, efforts to quit or cut down alcohol in the past, history of abstinence, reason for abstinence , reason for restarting alcohol consumption, previous history of alcoholics de-addiction treatment, belief in the effectiveness of alcohol de-addiction treatment in dealing with addiction, history of psychiatric hospitalisation, reason for hospitalisation, motivation to seek treatment and the source of information regarding treatment.

3. Rathus assertiveness schedule

This scale was developed by Rathus and Nevid. This is standardised tool consisting of thirty (30) items self report test on assertiveness. It has been shown to be valid with both normal and psychiatric populations. This scale may be used to estimate or assess whether or not the assertiveness training program has lead to a gain in the individual's assertive behaviour. The individual is asked to place himself in the particular situation each item describes, think how descriptive is it of him and mark the degree of response on a six point scale. The scale is a 6 point Likert rating scale to measure the level of assertiveness. It consists of positive and negative items. Scoring was based on the responses of the clients. Scores of the individual items are summed and total scores are obtained. Scores for each item ranged from -3 to +3. For items 3,6,7,8,9,10,18,20,21,22,25,27,28 and 29, the values ascribed to each of the 6 points are:

Score	Category
3	Very much like me
2	Rather like me
1	Slightly like me
-1	Very much unlike me
-2	Slightly unlike me
-3	Rather unlike me

For items 1,2,4,5,11,12,13,14,15,16,17,19,23,24,26 and 30 (scores are reversed in valence)**.** The obtainable score ranges from -90 to +90. Obtained scores are interpreted as follows:

Score	Interpretation
-90 to +20	Non-Assertive
+21 to +90	Assertive

"Higher the score, better the assertiveness skills"

4. Rosenberg's self-esteem scale

It is a standardised tool to measure self- esteem developed by Dr. Morris Rosenberg. This tool consists of 10 items with both positive and negative items. The scale is a 4 point likert scale. The scores for each item ranges from 0 to 3. (Strongly agree, Agree, Disagree, Strongly disagree). Scores of the individual items are summed to obtain the total score. For items 1, 2, 4, 6, and 7:

Score	Category
3	Strongly agree
2	Agree
1	Disagree
0	Strongly disagree

For items 3, 5, 8, 9, and 10 (which are reversed in valence). Obtained scores are interpreted as follows:

Score	Interpretation
<15	Low self-esteem
15-25	Normal
>25	High self-esteem

"Higher the score, higher the self- esteem."

4. Rating scale on the level of satisfaction upon assertiveness training among alcoholic patients

This scale was developed by the researcher based on the objectives of the study. This scale consisted of 10 items on satisfaction of the clients regarding various aspects of assertiveness training, rated on a four point scale, score ranging from 3-1 (Highly satisfied -3, satisfied-2, dissatisfied-1 and highly dissatisfied-0). The scale was used to assess the explanation given about the assertiveness training, the researcher's approach to the clients, time, duration, understanding ability, usefulness, involvement of the participants and the arrangements made during the program. Thus the total obtainable score range is 0-30. The obtained score is converted into percentage and is interpreted as follows,

Score	Interpretation
76-100%	Highly satisfied
51-75%	Satisfied
25-50%	Dissatisfied
Below 25%	Highly dissatisfied

Psychometric Properties of the Instruments

Validity

The content validity refers to the degree to which the item on an instrument adequately represents the universe of the content (Polit & Beck, 2010). Rathus assertiveness schedule and Rosenberg self- esteem scale are standardised instruments and permission was obtained from the author to use it. The other proformas and scales were certified and validated by seven experts. The modifications and suggestions of experts were incorporated in the final preparation of the tool.

Reliability

Reliability refers to the accuracy and consistency of measuring tool (Polit & Beck, 2010).

1. Rathus assertiveness schedule

Rathus assertiveness schedule is a standardised tool developed by Rathus and Nevid. Original version of Rathus assertiveness schedule has internal consistency (alpha 0.94); split half reliability (0.94) and test retest correlation of over a week. The reliability of the translated version in Tamil is established by split half method and the reliability score was 0.83.

2. Rosenberg self-esteem scale

Rosenberg self-esteem scale is a standardised tool developed by Dr. Morris Rosenberg. Reliability score of Rosenberg self- esteem scale is 0.88, which indicates that the tool is highly reliable.

3. Rating scale on the level of satisfaction upon assertiveness training among alcoholic patients

The satisfaction scale was tested using split half method and the reliability was found to be 0.79, indicating that the tool is highly reliable.

Pilot Study

Polit and Beck (2010) states that pilot study is a miniature of some parts of the actual study in which the instruments are administered to the subjects drawn from the same population. It is a small scale version or trial run done in preparation for the major study. The purpose is to find out the feasibility and practicability of the study design. The pilot study was conducted among 10 alcoholic patients in Grace foundation and Concern rehabilitation centre. Formal permission was obtained from the authorities of both the de-addiction centres prior to pilot study.

The samples were chosen by purposive sampling technique, 5 in the control group and 5 in the experimental group. Assertiveness training was given for one hour over a period of seven days to the experimental group. There was no intervention for the control group of alcoholic patients. The level of assertiveness skills and self-esteem scores was assessed for both the control and experimental group after one week. Then the level of satisfaction on assertiveness training was assessed using the rating scale for experimental group. The results of the pilot study revealed that that the present study was feasible to conduct.

Protection of Human Rights

Permission was obtained from the Ethical Committee, Apollo Hospitals, Chennai and the Managerial authorities of the de-addiction centres to conduct the study,

in Freedom care and foundation, Sithalapakkam and Wisdom hospitals, Saidapet. The researcher obtained informed consent from the alcoholic patients to participate in the study. An assurance was given regarding confidentiality before the data collection procedure.

Data Collection Procedure

The data collection is the gathering of information needed to address a research problem. Data collection for the investigation was accomplished during a one month period from 17 June, 2011 to 17 July, 2011. Prior to the start of the actual study, the researcher was trained in an intensive one week workshop on assertiveness training.

The settings were randomised and allotted to the control and experimental group. After initial introduction, the researcher obtained informed consent from the alcoholic patients to participate in the study. By purposive sampling technique, 30 alcoholic patients in each setting were selected. Rathus assertiveness schedule and Rosenberg's self-esteem scale was administered to all the inpatients. The alcoholic patients in the experimental group received, in addition to the treatment program, ten hours of assertiveness training over a period of two weeks. The data collection was done as one hour session per day. The researcher utilised all the components of assertive training like modelling, coaching, role playing, instructions, behaviour rehearsal, feedback and graded-structured exercises.

Techniques like fogging, broken–record and negative assertion were employed. Activities like practice sessions with detailed exercises, worksheets, video shows, games and innovative methods with lecture cum discussion using power point presentation were held. It mainly focused on assertiveness skills and the core factors of assertiveness. The program was conducted mainly in the mornings between 11 am to

12 pm. Each patient was asked to discuss situations in his or her own life which were proving problematic. Much of the focus of this group was to develop skills in precisely those aspects of unassertiveness in which the client was having difficulty. The alcoholic patients were given a theoretical rationale for their treatment and they were strongly encouraged to begin behaving assertively.

The alcoholic patients in the control group were allowed to participate in all alcoholism unit treatment and activities except those involving assertiveness training. On the 15th day, the scores for assertiveness skills and self-esteem were assessed by the Rathus assertiveness schedule and Rosenberg's self-esteem scale both in the control and experimental group. Then level of satisfaction regarding administration of assertiveness training was assessed using rating scale for level of satisfaction in the experimental group. Assertive treatment was given to the alcoholic patients in the control group after termination of the study.

Problems Faced during Data Collection

The alcoholic patients and the concerned authorities were very co-operative and there were no problems during data collection and intervention.

Plan for Data Analysis

Data analysis is the systematic organization and synthesis of research data and testing of null hypothesis by using the obtained data (Polit & Beck, 2010). Analysis and interpretation of data were carried out with descriptive statistics such as frequency, percentage, mean and standard deviation and inferential statistics such as independent't' test and chi-square test.

Summary

This chapter has dealt with the selection of research approach, research design, setting, population, sample, sampling technique, sampling criteria, selection and development of study instruments, validity and reliability of study instruments, pilot study, data collection procedure and plan for data analysis. The following chapter deals with analysis and interpretation of data using descriptive and inferential statistics.

CHAPTER – IV

ANALYSIS AND INTERPRETATION

Data analysis is conducted to reduce, organize and give meaning to the data. The results obtained from data analyses require interpretation to be meaningful. Interpretation of data involves examining the results from data analysis forming conclusions, considering the implications for nursing, exploring the significance of the findings and suggesting further studies (Polit & Beck, 2010).

This chapter deals with analysis and interpretation of data including both descriptive and inferential statistics. The data were analysed according to the objectives and hypothesis of the study. Analysis of the data was compiled after all the data was transferred to the master coding sheet. The data were analyzed, tabulated and interpreted using appropriate descriptive and inferential statistics.

Organisation of the Findings

The findings of the study was organised and presented under the following headings.

- Frequency and percentage distribution of selected demographic variables in the control and experimental group of alcoholic patients.
- Frequency and percentage distribution selected clinical variables in the control and experimental group of alcoholic patients.
- Frequency and percentage distribution of level of assertiveness skills and self-esteem before and after AST in the control and experimental group of alcoholic patients.

- Domain wise frequency and percentage distribution of level of satisfaction scores of assertiveness training in the experimental group of alcoholic patients.

- Comparison of mean and standard deviation of assertiveness skills and self-esteem scores before AST between control and experimental group of alcoholic patients and after AST between control and experimental group of alcoholic patients.

- Association between the selected demographic variables and the level of assertiveness skills before and after AST in the control and experimental group of alcoholic patients.

- Association between the selected demographic variables and the level of self-esteem before and after AST in the control and experimental group of alcoholic patients.

- Association between the selected clinical variables and the level of assertiveness skills before and after AST in the control and experimental group of alcoholic patients.

- Association between the selected clinical variables and the level of self-esteem before and after AST in the control and experimental group of alcoholic patients.

Table .1

Frequency and Percentage Distribution of Demographic Variables in the Control and Experimental Group of Alcoholic Patients

Demographic Variables	Control Group (n=30)		Experimental Group (n=30)	
	n	p	n	p
Age (in years)				
≤ 20	3	10	5	16.67
20-30	9	30	16	53.33
31-40	8	26.67	4	13.33
41-50	4	13.33	5	16.67
51	6	20	-	-
Mean age in years	**36.97**		**37.4**	
Educational status				
Non literate	-	-	-	-
Primary education	2	6.67	7	23.33
Secondary education	5	16.67	5	16.67
Higher secondary	9	30	7	23.33
Graduate and above	14	46.67	11	36.67
Monthly family income (in Rs.)				
≤ 10,000	11	36.67	17	53.33
10,001 – 20,000	11	36.67	8	26.67
20,001 – 30,000	4	13.33	3	10
>30,000	4	13.33	2	6.67
Average monthly family income (in Rs.)	**Rs. 20,823**		**Rs. 14, 077**	
Number of children				
No children	1	7.69	5	31.25
One	4	30.77	5	31.25
Two	6	46.15	7	43.75
More than two	2	15.38	3	18.75
Religion				
Hindu	21	70	26	86.67
Muslim	2	6.67	2	6.67

Christian	6	20	2	6.67
Others	1	3.33	-	-
Type of the family				
Nuclear	10	33.33	14	46.67
Joint	13	43.33	15	50
Extended	7	23.33	1	3.33
Family history of alcohol abuse/ dependence				
No	11	36.67	10	33.33
Yes	19	63.33	20	66.67
If yes, Relationship with the client				
Father	10	52.63	14	70
Brother	6	31.58	8	40
Son	1	5.26	1	5
Uncle	1	5.26	-	-
Brother – in – law	1	5.26	-	-

It can be noted in table 1 that, a significant percentage of the alcoholic patients were in the age group of 20-30 years (30%, 53.33%), earned a monthly family income of ≤ 10,000 rupees (36.67%, 53.33%), were graduates (46.67%, 36.67%), had two children (46.15%, 43.75%), belonged to joint family (43.33%, 50%), had a family history of alcohol abuse/ dependence (63.33%, 66.67%) in the control and experimental group respectively. Majority of them were Hindus (70%, 86.67%) in the control and experimental group respectively.

Figure 3 shows that a significant percentage of alcoholic patients were labourers (26.67%, 43.33%) in the control and experimental group respectively.

Figure 4 depicts that most of them were unmarried in the control group (53.13 %,) and married in the experimental group (66.67%) respectively.

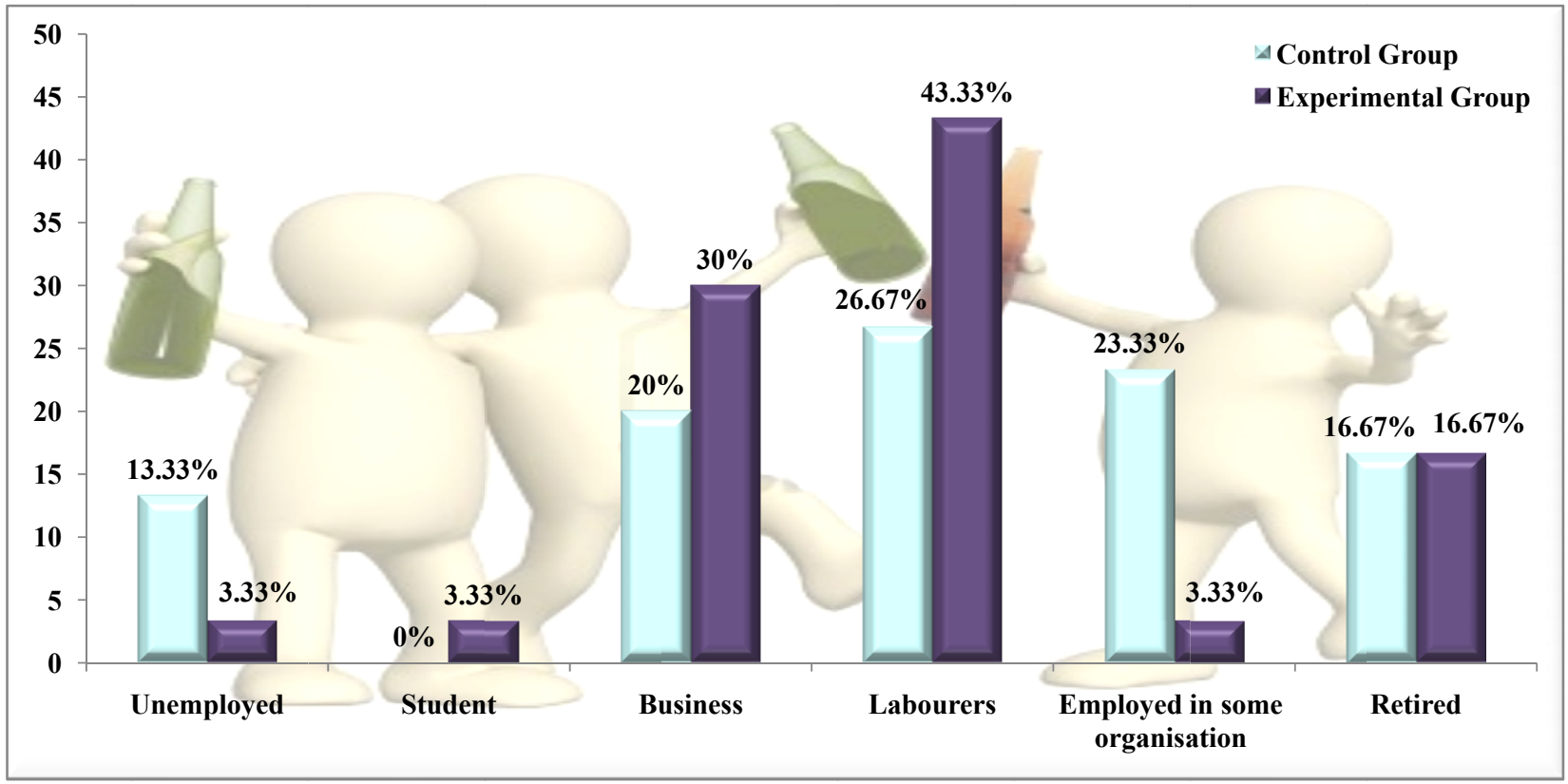

Fig 3: Percentage Distribution of Occupation in the Control and Experimental Group of Alcoholic Patients

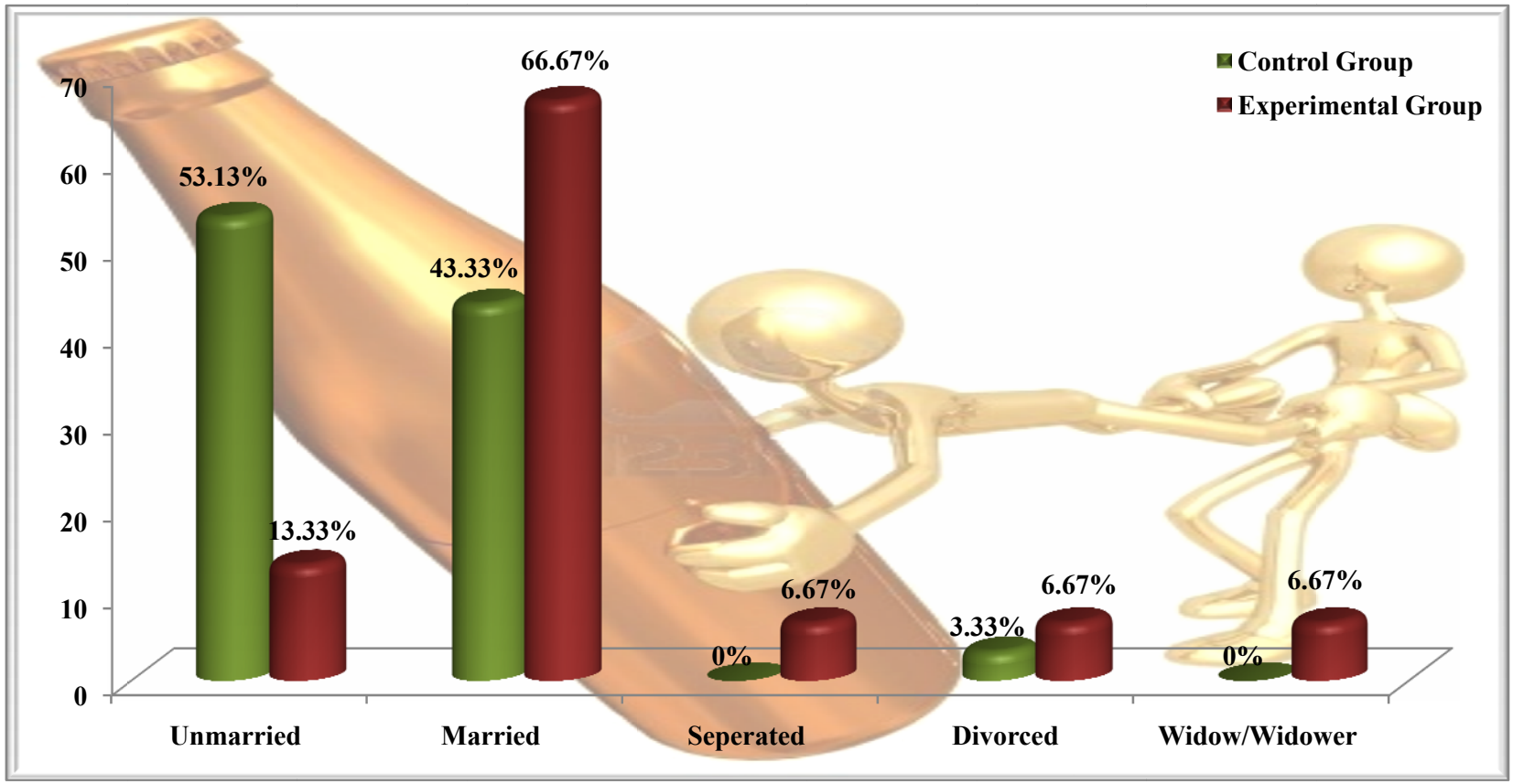

Fig 4: Percentage Distribution of Marital Status in the Control and Experimental Group of Alcoholic Patients

Table.2

Frequency and Percentage Distribution of Selected Clinical Variables in the Control and Experimental Group of Alcoholic Patients

Clinical variables	Control Group (n=30)		Experimental Group (n=30)	
	n	p	n	p
Age at which the alcohol consumption was started (in years)				
≤ 20	15	50	17	56.67
21-25	9	30	7	23.33
26-30	5	16.67	2	6.67
>30	1	3.33	4	13.33
Mean age of onset (in years)	**21.2**		**21.17**	
Duration of alcohol dependence (in years)				
≤ 10	14	46.67	11	36.67
11 - 20	10	33.33	9	30
21 -30	3	10	7	23.33
31 – 40	3	10	2	6.67
> 40	-	-	1	3.33
Average duration of alcohol dependence (in years)	**16.63**		**14.47**	
Precipitating factor for alcohol consumption				
Peer pressure/ Influence	16	53	14	46.67
Curiosity	13	43.33	19	63.33
Religious/ Social acceptance	3	10	-	-
Family problems	8	26.67	4	13.33
Financial problems	7	23.33	3	10
like the taste	9	30	9	30
For enjoyment/ Pleasure	22	73.33	20	66.67
To forget/ escape from problems	9	30	10	33.33
Seeing others using	4	13.33	5	16.67
To manage feelings of anger, loss or other emotional pain	12	40	11	36.67
Fatigue	3	10	7	23.33
Excessive worries	7	23.33	9	30
Insomnia	4	13.33	5	16.67

Academic failure	7	23.33	4	13.33
Difficulty in concentration	4	13.33	1	3.33
To be smart (Heroism)	4	13.33	7	23.33
Lack of interest in day to day life	4	13.33	7	23.33
To have self confidence	5	16.67	8	26.67
To overcome shyness	6	20	7	23.33
Love failure	11	36.67	3	10
Pain/ Other physical illness	4	13.33	3	10
Acculturation	2	6.67	2	6.67
Poverty	3	10	1	3.33
Unemployment	3	10	2	6.67
Influence of cinema	4	13.33	5	16.67
Isolation	3	10	-	-
Situations that provoke to consume more amount of alcohol				
Peer pressure / Influence	13	43.33	16	53.33
Work load	5	16.67	12	40
Tension	9	30	4	13.33
Anxiety	9	30	6	20
Thinking about any problems	13	43.33	8	26.67
Seeing others using	7	23.33	12	40
Presence of other abusers	2	6.67	5	16.67
Leisure time	9	30	9	30
Development of tolerance	19	63.33	19	63.33
Sight of alcohol	8	26.67	10	33.33
Shooting Gallery/Alcohol taking restaurant	7	23.33	5	16.67
Advertisements	1	3.33	-	-
Pain/ Other Physical Problems	5	16.67	6	20
Any special occasion	7	23.33	10	33.33
Amount of alcohol consumed per day (in ml)				
≤ 250	9	30	9	30
251-500	10	33.33	16	53.33
501-750	10	33.33	3	30
>750	1	3.33	2	6.67
Average amount of alcohol consumed per day	**400**		**438**	

Money spent on alcohol consumption per Day (in Rs.)				
≤ 250	15	50	15	50
251-500	13	43.33	11	36.67
501-750	1	3.33	-	-
>750	1	3.33	4	13.33
Average expenditure on alcohol per day	**458**		**318**	
Any associated symptoms				
Tremors in hands & fingers	18	60	20	66.67
Feeling of choking	3	10	13	43.33
Nervousness	9	30	11	36.67
Sleep disturbances	16	53.33	15	50
Eating less	17	56.67	19	63.33
Memory disturbances	14	46.67	7	23.33
Hearing voices / Seeing things when alone	4	13.33	4	13.33
Others	1	3.33	1	3.33
Fatigue	-	-	1	100
Palpitations	1	100	-	-
History of associated complications				
Heart disease	-	-	5	16.67
Diabetes	1	3.33	2	6.67
Lung disease	2	6.67	1	3.33
Peripheral neuropathy	3	10	-	-
Liver disease	3	10	3	10
Cancers	9	30	5	16.67
Birth defects	4	13.33	-	-
Depression	8	26.67	12	40
Others	-	-	1	33.33
Hypertension	-	-	1	100
Efforts to quit or cut down alcohol in the past				
Yes	28	93.33	23	76.67
No	2	6.67	7	23.33
History of abstinence				
Yes	28	100	23	100
No	-	-	-	-

Reason for abstinence				
Religious motive	1	3.57	2	8.67
To pursue studies	1	3.57	-	-
Rehabilitation	1	3.57	-	-
Special occasions	1	3.57	-	-
Self-control	6	21.43	4	17.39
Family responsibility	4	14.28	1	4.35
Family pressure	2	7.14	3	13.04
Financial difficulty	1	3.57	-	-
Fear of physical illness	5	17.86	3	13.04
Development of physical illness	1	3.57	-	-
Damage to reputation	1	3.57	1	4.35
Fed up of using alcohol	4	14.28	3	13.04
Desiring peaceful life	-	-	2	8.69
Conflicts in relationships	-	-	4	17.39
Reason for restarting alcohol consumption				
Difficulty in concentration	4	14.28	7	30.43
Loss of pressure	11	39.29	14	60.87
Craving	10	35.71	14	60.87
Withdrawal symptoms	4	14.28	7	30.43
Peer pressure / Influence	10	35.71	6	26.09
Experimentation	8	28.57	9	39.13
Controlled intake	9	32.14	14	60.87
Others	3	10.71	3	13.04
Isolation	-	-	2	6.67
Excessive worries	-	-	1	33.33
Pain	1	33.33	-	-
Excessive workload	1	33.33	-	-
To gain confidence	1	33.33	-	-
Previous history of alcohol de- addiction treatment				
Yes	22	73.33	21	70
No	8	26.67	9	30
Belief in effectiveness of alcohol de- addiction treatment in dealing with addiction				
Yes	25	83.33	21	70
No	5	16.67	9	30

History of psychiatric hospitalisation				
Yes	10	33.33	7	23.33
No	20	66.67	23	76.67
The reason for psychiatric hospitalisation				
Depression	3	30	4	57.14
Fear	1	10	1	14.29
Conflicts in relationships	1	10	2	28.57
Difficulty in concentration	2	20	-	-
Epileptic psychosis	1	10	-	-
Insomnia	2	20	-	-
Others	-	-	-	-
Motivation to seek treatment				
Wish to improve oneself	17	56.67	15	50
Availability and awareness of treatment	5	16.67	4	13.33
Family pressure	11	36.67	2	6.67
Family responsibility	22	73.33	18	60
Social Disapproval	12	40	12	40
Difficulty in getting substance	2	6.67	7	23.33
Fear of physical illness	13	43.33	1	3.33
Development of physical illness	4	13.33	12	40
Fear of loss of job	4	13.33	2	6.67
Due to religious values	1	3.33		0
Observing recovered ones	3	10	7	23.33
Financial difficulties (Inability to afford)	5	16.67	5	16.67
Fed up of using alcohol	11	36.67	7	23.33
Reason for which alcohol was used was not fulfilled	2	6.67	2	6.67
Accidents	5	16.67	8	26.67

It can be inferred from table 2 that, most of the alcoholic patients in the control and experimental group started consuming alcohol at the age of ≤ 20 years (50%, 56.67%), with the duration of ≤ 10 years (46.67%, 36.67%), stated enjoyment/ pleasure as the precipitating factor for alcohol consumption (73.33%, 66.67%), tolerance as the situation that provoked them to consume more amount of alcohol (63.33%, 63.33%),

had tremors in hands and fingers (60%, 66.67%), had a previous history of alcohol de-addiction treatment (73.33%, 70%), believed in alcohol de-addiction treatment to be effective (83.33%, 73.33%) and stated family responsibility as the motivation to seek treatment (73.33%, 60%) respectively.

Majority of them made an effort to quit or cut down alcohol in the past (93.33%, 76.67) and were abstinent (100%, 100%) at least once for a brief period in the control and experimental group respectively. A significant percentage of them consumed an amount of ≤ 250 ml per day (30%, 30%), spent an amount of ≤ 250 rupees (50%, 50%), developed complications like depression (26.67%, 40%), stated self-control as the reason for abstinence (21.43%, 17.39%), stated loss of pleasure as the reason for restarting alcohol consumption after a period of abstinence (39.29%, 60.87%), had a history of psychiatric hospitalisation (33.33%, 23.33%) and stated depression as the reason for psychiatric hospitalisation (30%, 57.14) in the control and experimental group respectively.

Figure 5 shows that, a significant percentage of the alcoholic patients were excited when they first consumed alcohol in the control and experimental group of alcoholic patients (44%, 76.67%) respectively.

Figure 6 portrays that most of them consumed alcohol everyday (57%, 60%) in the control and experimental group respectively.

Figure 7 depicts that majority of them used brandy (73.333%, 86.67%) in the control and experimental group respectively.

Figure 8 shows that, majority of them spent their own earning to buy alcohol in the control and experimental group (80%, 86.67%) respectively.

Figure 9 illustrates that, majority of the alcoholic patients predominantly used tobacco smoking along with alcohol (76.67%, 76.67%) in the control and experimental group respectively.

Figure 10 portrays that, majority of them stated conflicts in relationship as the problem arisen due to alcohol consumption (80%, 86.67%) in the control and experimental group respectively.

Figure 11 depicts that, a significant percentage of them stated family and neighbours as the source of information regarding treatment (47%, 30%) in the control and experimental group respectively.

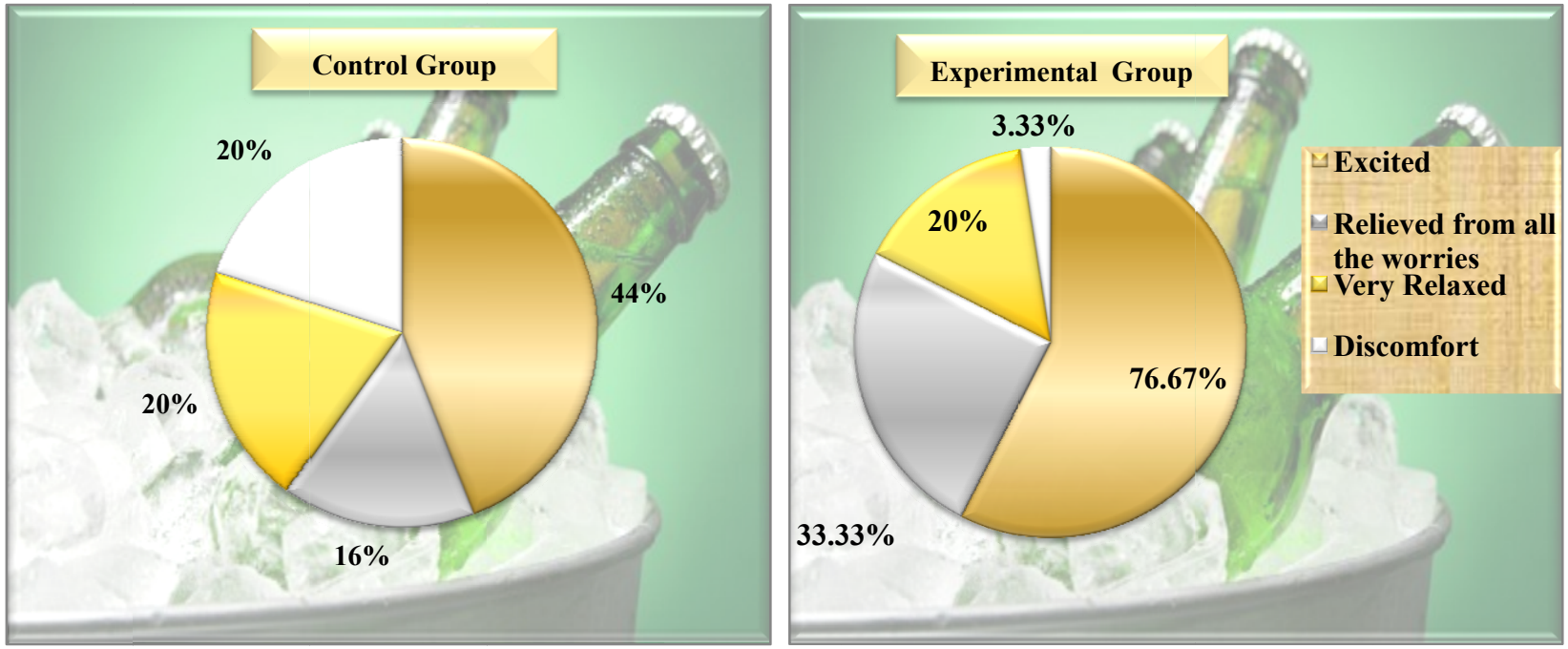

Fig 5: Percentage Distribution of Feelings when one First Consumed Alcohol in the Control and Experimental Group of Alcoholic Patients

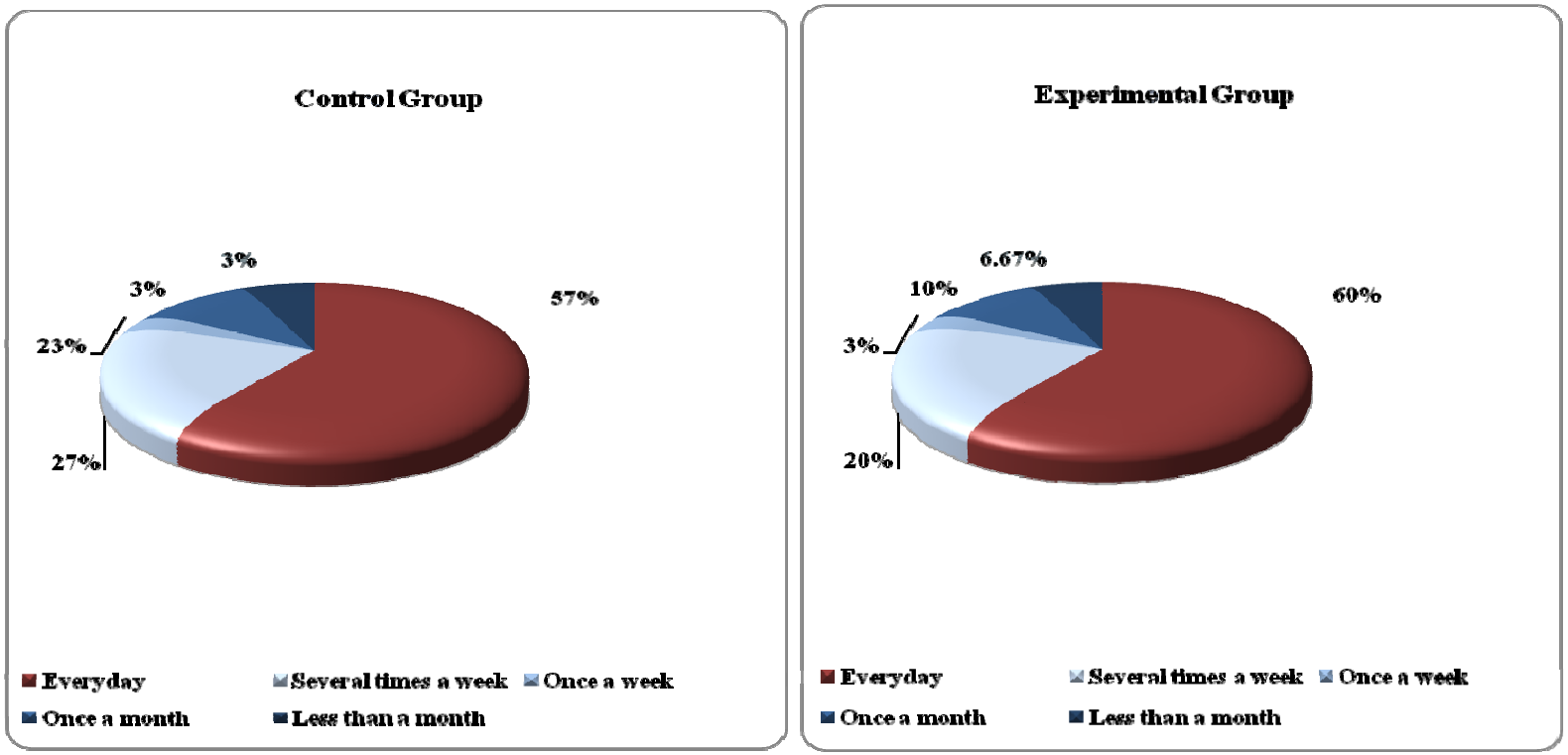

Fig 6: Percentage Distribution of Frequency of Alcohol Consumption in the Control and Experimental Group of Alcoholic Patients

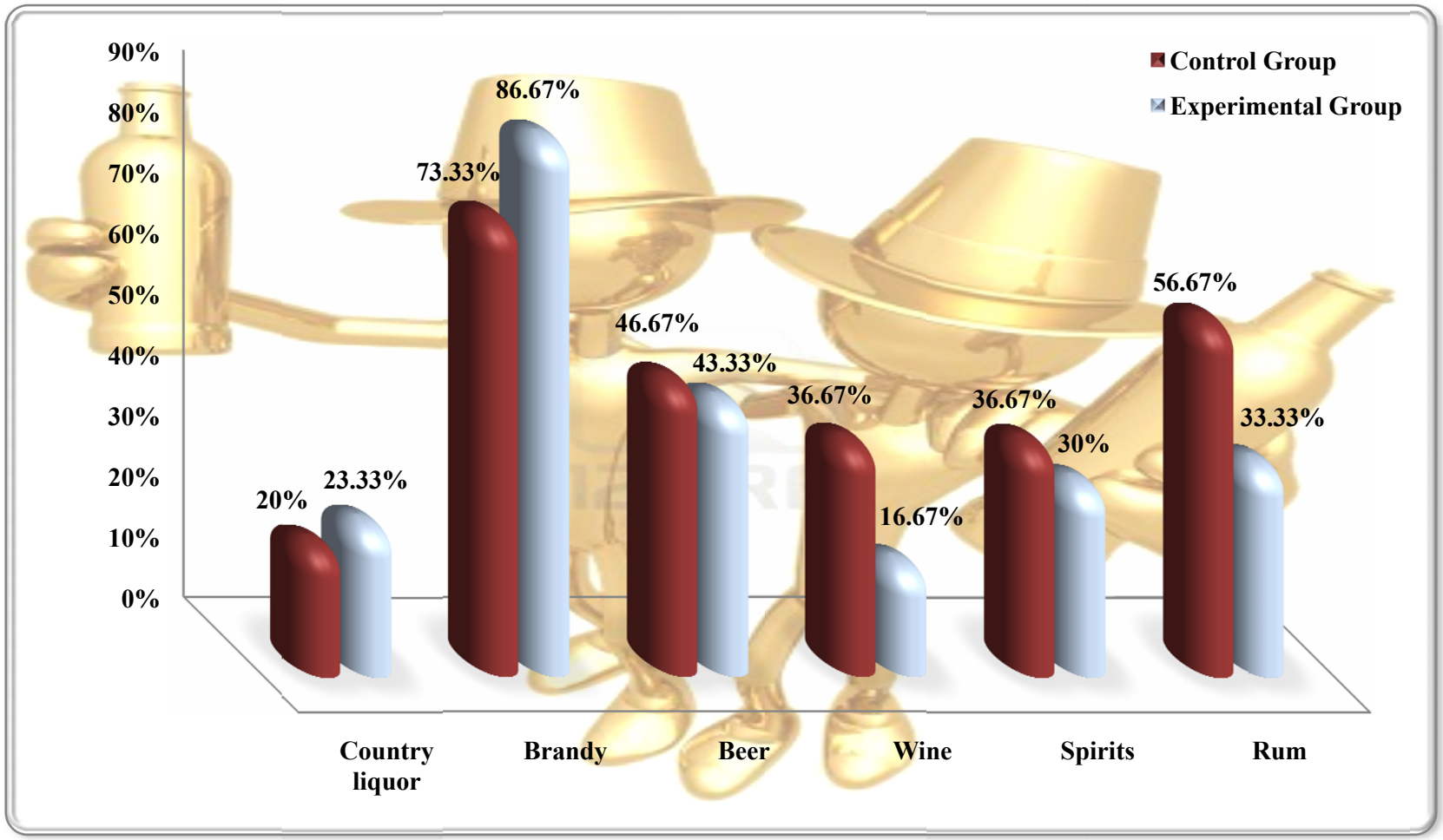

Fig 7: Percentage Distribution of Form of Alcohol Used in the Control and Experimental Group of Alcoholic Patients

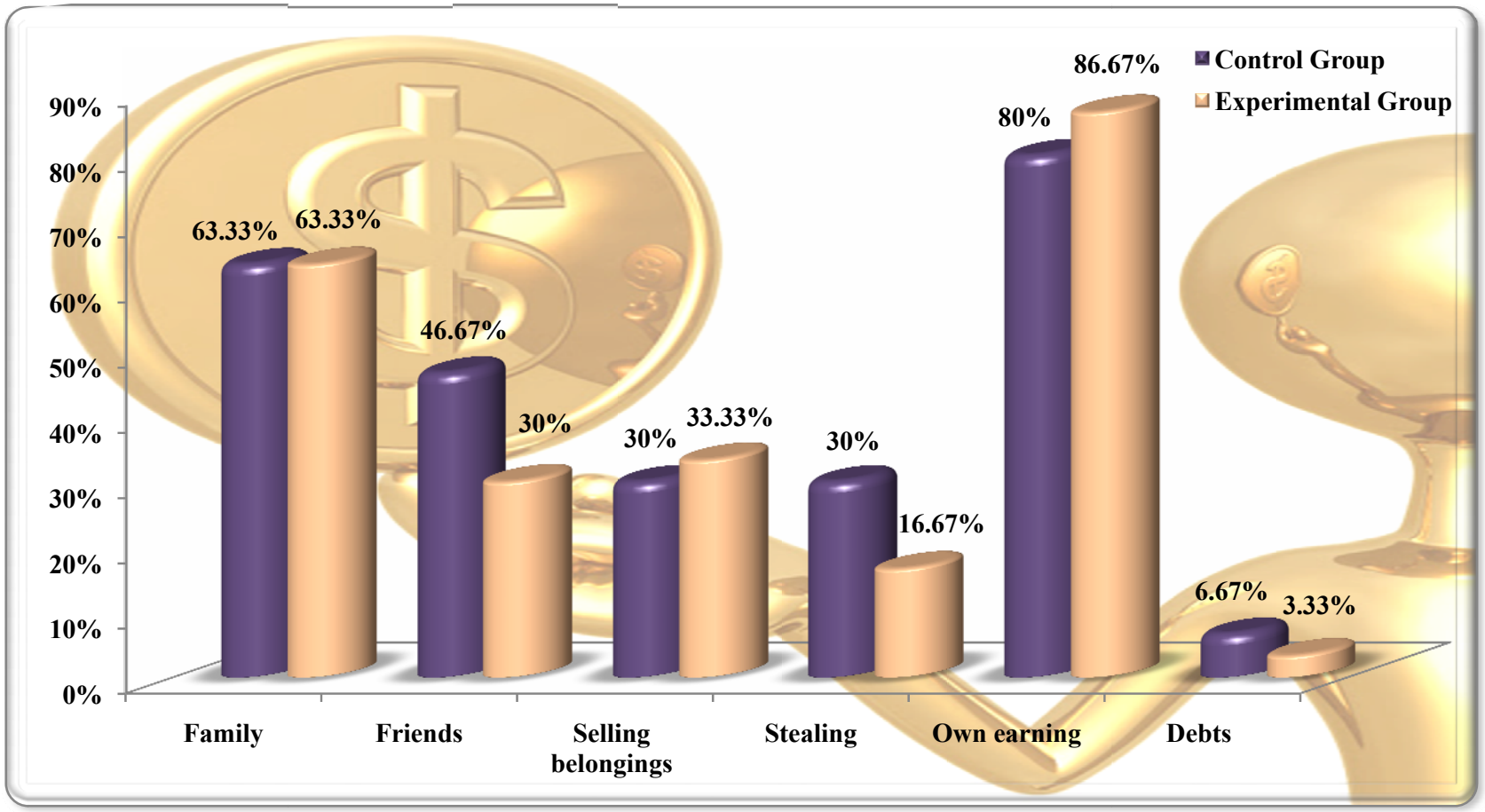

Fig 8: Percentage Distribution of Source of Money to Buy Alcohol in the Control and Experimental Group of Alcoholic Patients

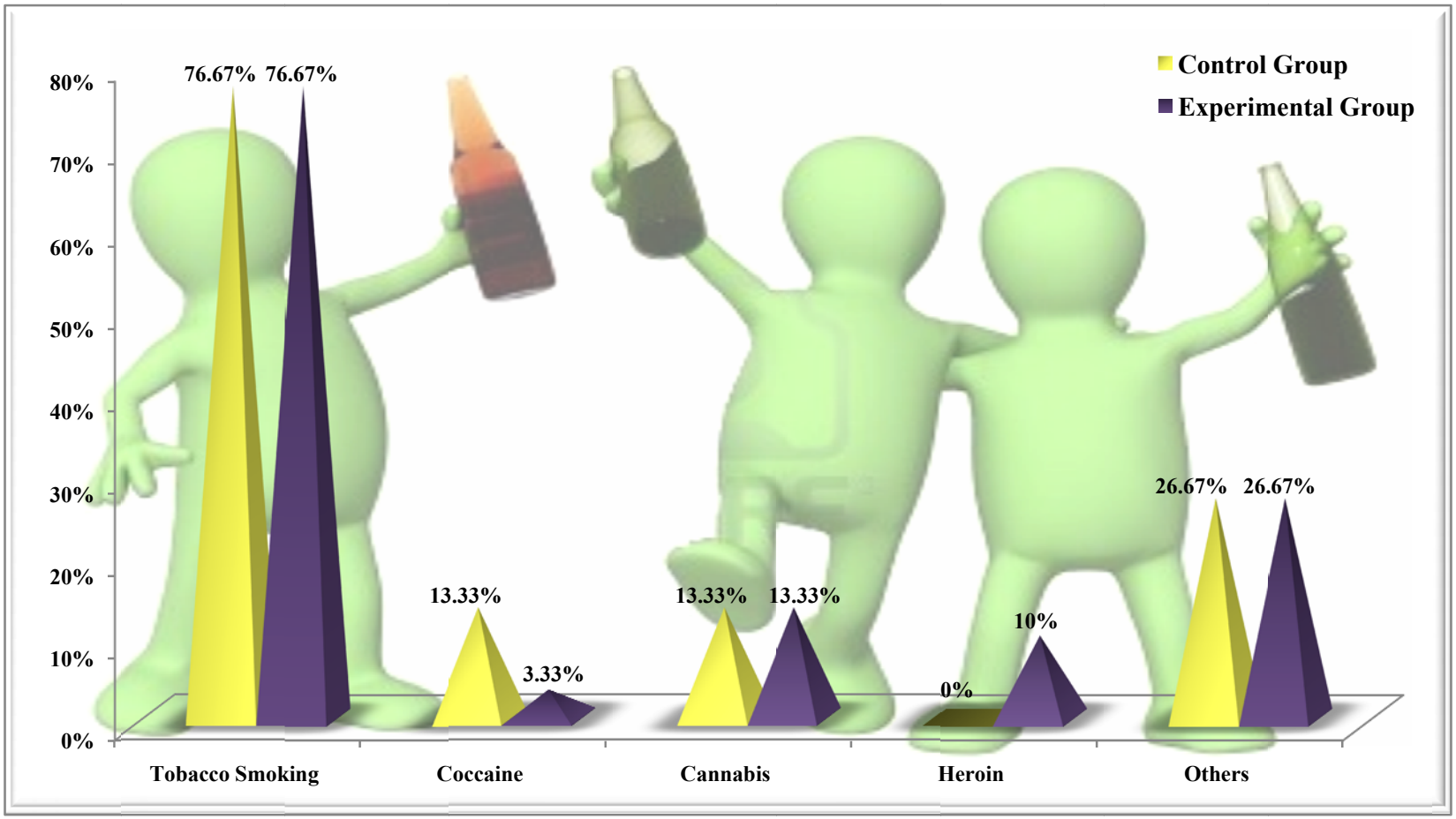

Fig 9: Percentage Distribution of History of Usage of Other Addictive Agents in the Control and Experimental Group of Alcoholic Patients

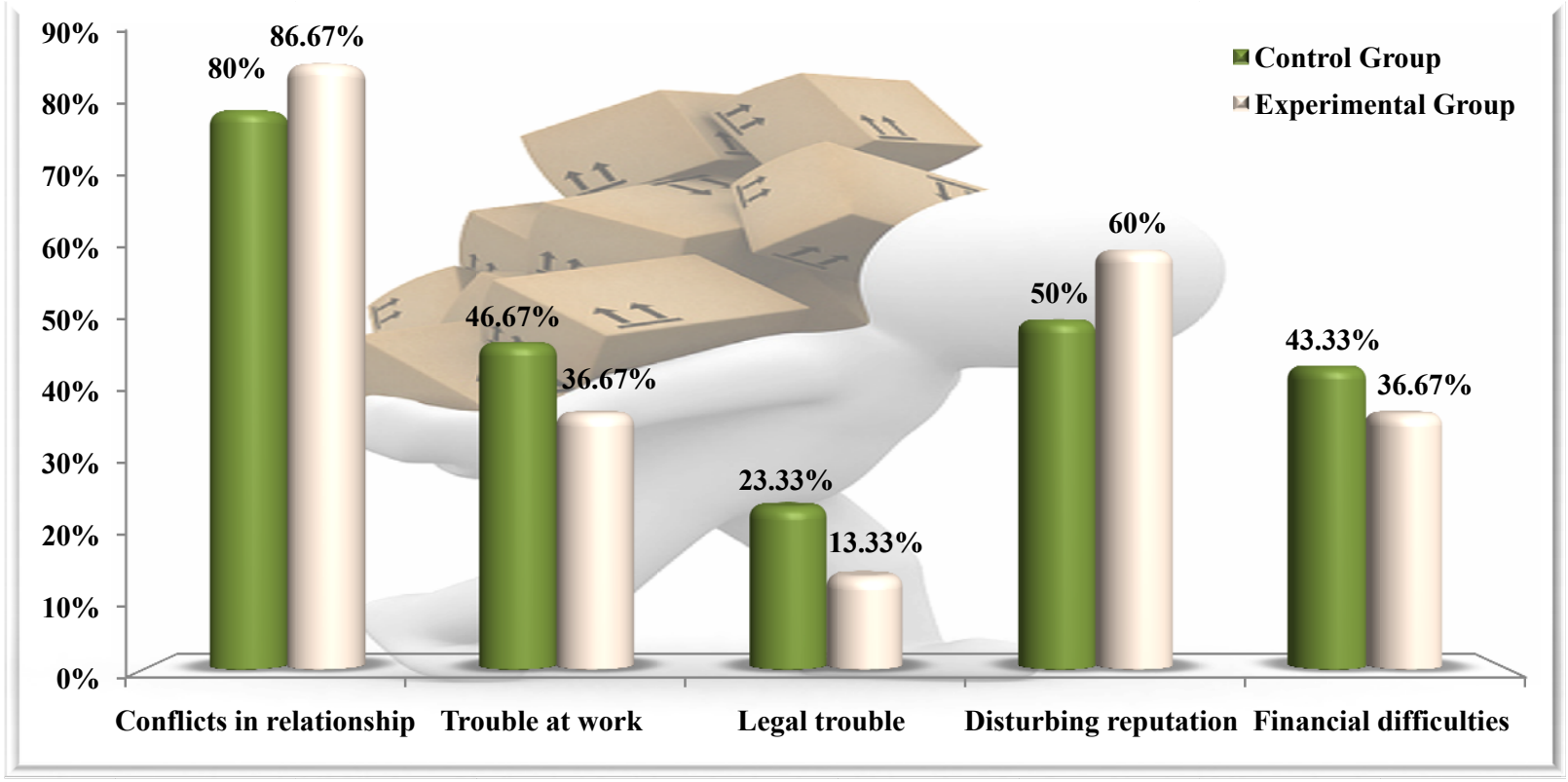

Fig 10: Percentage Distribution of Problems Arisen due to Alcohol Consumption in the Control and Experimental Group of Alcoholic Patients

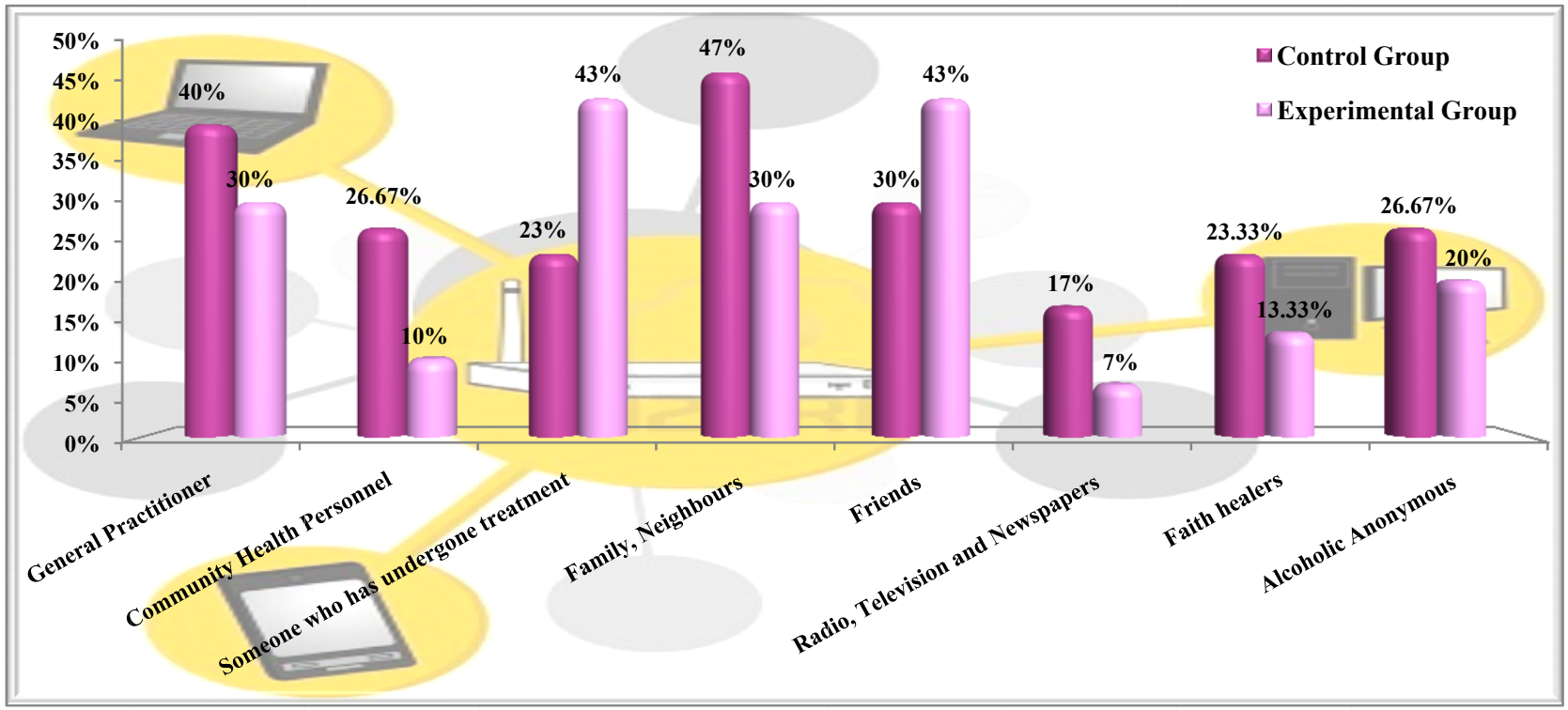

Fig 11: Percentage Distribution of Source of Information Regarding Treatment in the Control and Experimental Group of Alcoholic Patients

Table 3

Frequency and Percentage Distribution of Level of Assertiveness Skills and Self-Esteem in the Control and Experimental Group of Alcoholic Patients Before and After AST

Variables	Control Group (n=30)				Experimental Group (n=30)			
	Before AST		After AST		Before AST		After AST	
	n	p	n	p	n	p	n	p
Assertiveness skills								
Non-assertive	29	96.7	29	96.7	28	93.3	11	36.7
Assertive	1	3.3	1	3.3	2	6.7	19	63.3
Self-esteem								
Low	9	30	6	20	9	30	1	3.33
Normal	21	70	24	80	21	70	23	76.67
High	-	-	-	-	-	-	6	20

AST- Assertiveness training

It can be inferred from table 3 that majority of the alcoholic patients in the control group were non-assertive and had normal level of self-esteem before (96.7%, 70%) and after (96.67%, 80%) AST respectively. None of them had high self-esteem. In the experimental group, most of the alcoholic patients were non-assertive and had normal level of self-esteem before AST (93.3%, 70%). However, after the administration of AST, most of them were assertive (63.3%) and majority of them had normal level of self-esteem (76.67%) in the experimental group of alcoholic patients respectively. Twenty percent of them had high self- esteem after AST. This can be ascribed to the effectiveness of AST.

Table 4

Domain Wise Frequency and Percentage Distribution of Level of Satisfaction Scores of Assertiveness Training in the Experimental Group of Alcoholic Patients

Domain	Experimental group (n=30)							
	Highly satisfied		Satisfied		Dissatisfied		Highly dissatisfied	
	n	p	n	p	n	p	n	p
Overall satisfaction	28	93.33	2	6.67	-	-	-	-
Related to the researcher	4	13.33	17	56.67	9	30	-	-
Related to assertiveness training	28	93.33	2	6.67	-	-	-	-

It can be inferred from the table 4 that majority of them (93.33%) were highly satisfied with all the aspects of assertiveness training.

Table 5

Comparison of Mean and Standard Deviation of Assertiveness Skills and Self-Esteem Scores Before AST between Control and Experimental Group of Alcoholic Patients and After AST between Control and Experimental Group of Alcoholic Patients

Groups	n	Before AST			After AST		
		Mean	S.D.	't' value	Mean	S.D.	't' value
Assertiveness Skill Global score							
Control group	30	-2.47	12.78	0.26	-2.60	13.34	**9.16*****
Experimental group	30	-3.30	12.25		24.83	9.56	
Interpersonal communication							
Control group	30	-4.27	6.02	0.66	-4.40	5.98	**5.52*****
Experimental group	30	-5.30	6.17		4.40	6.36	
Self-concept							
Control group	30	-2.53	7.28	0.44	-1.37	7.61	**5.34*****
Experimental group	30	-1.73	6.77		8.10	6.05	
Public speaking							
Control group	30	3.27	7.14	0..27	3.17	7.20	**5.7*****
Experimental group	30	3.73	6.04		12.33	4.92	
Self- Esteem							
Control group	30	16.93	3.52	1.23	17.37	3.06	**6.83*****
Experimental group	30	15.7	4.25		21.9	3.54	

***p< 0.001.

The data presented in table 5 depicted that the mean and standard deviation for scores of assertiveness skills (M=-2.47, SD=12.78), (M=-3.30, SD=12.25) and self-esteem (M=16.93, SD=3.52), (M=15.7, SD=4.25) among alcoholic patients before AST in the control and experimental group was not significant at $p>0.05$. On the other hand, after the administration of AST, the mean and standard deviation of assertiveness skills (M=2.60, SD=13.34) and self-esteem (M=17.37, SD=3.06) of control group were less in comparison with the assertiveness skills (M=24.83, SD=9.56) and self-esteem (M=21.9, SD=3.54) scores of experimental group. The difference was found statistically significant at $p<0.001$ level of confidence and it can be accredited to the effectiveness of AST.

The table also shows that the mean and standard deviation scores for dimensions interpersonal communication (M=-4.27, SD=6.02), (M=-5.30, SD=6.17), self-concept (M=-2.53, SD=7.28), (M=-1.73, SD=6.77), public speaking (M=3.27, SD=7.14), (M=3.73, SD=6.04) before AST for control and experimental group was not significant at $p>0.05$. However after the administration of AST the mean and standard deviation scores for dimensions interpersonal communication (M=-4.40, SD=5.98), (M=4.40, SD=6.36), self-concept (M=-1.37, SD=7.61), (M=8.01, SD=6.05), public speaking (M=3.17, SD=7.20), (M=12.33, SD=4.92) in the experimental group was significant at $p<0.001$ level of confidence. It can thus be inferred that the AST was effective.

Hence the null hypothesis Ho_1 "There will be no significant difference in the level of assertiveness skills and self-esteem before and after assertiveness training in the control and experimental group of alcoholic patients" was rejected.

Table 6

Association between the Selected Demographic Variables and the Level of Assertiveness Skills in the Control and Experimental Group of Alcoholic Patients Before and After AST

Demographic Variables	Control Group (n=30) Before AST			Control Group (n=30) After AST			Experimental Group (n=30) Before AST			Experimental Group (n=30) After AST		
	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2
Age (in years)												
≤ 40	10	10	1.09	9	11	3.32	18	7	**4.85***	13	12	0.24
> 40	7	3	(df =1)	8	2	(df =1)	1	4	(df =1)	2	3	(df =1)
Educational status												
Graduates and above	9	5	0.62	9	5	0.62	5	6	2.39	6	5	0.14
Others	8	8	(df =1)	8	8	(df =1)	14	5	(df =1)	9	10	(df =1)
Occupation												
Unemployed & labourers	6	6	0.36	5	7	1.09	11	3	2.62	7	7	0
Employed	11	7	(df =1)	11	7	(df =1)	8	8	(df =1)	8	8	(df =1)
Marital status												
Married	17	13	-	17	13	-	12	8	0.29	11	9	0.60
Others	17	13	(df =1)	17	13	(df =1)	7	3	(df =1)	4	6	(df =1)
Monthly family income (in Rs.)												
≤ 10,000	7	4	0.35	7	4	0.74	12	5	0.88	7	10	1.22
> 10,000	10	9	(df =1)	9	10	(df =1)	7	6	(df =1)	8	5	(df =1)
Religion												
Hindu	14	7	2.85	14	7	2.85	18	8	2.92	13	13	-
Others	3	6	(df =1)	3	6	(df =1)	1	3	(df =1)	2	2	(df =1)
Type of the family												
Nuclear	5	5	0.27	4	6	1.69	9	5	0.10	7	8	-
Others	12	8	(df =1)	13	7	(df =1)	10	6	(df =1)	7	8	(df =1)
Family history of alcohol abuse/ dependence												
Yes	9	10	1.91	9	10	0.74	13	7	0.07	8	12	2.40
No	8	3	(df =1)	7	4	(df =1)	6	4	(df =1)	7	3	(df =1)

*p < 0.05.

Note: Categories under the variables were clubbed for the sake of chi-square analysis.

It could be inferred from the table 6 that there is a significant association between age and assertiveness skills ($p<0.05$). Hence the null hypothesis Ho_2 "There will be no significant association between age and the level of assertiveness skills before and after assertiveness training among control and experimental group of alcoholic patients" was rejected.

However there is no significant association between other demographic variables like educational status, occupation, marital status, monthly family income, religion, type of the family, family history of alcohol abuse/ dependence and the level of assertiveness skills ($p > 0.05$). In this regard, the null hypothesis Ho_2 "There will be no significant association between other selected demographic variables such as educational status, occupation, marital status, monthly family income, religion, type of the family, family history of alcohol abuse/ dependence and the level of assertiveness skills before and after assertiveness training among control and experimental group of alcoholic patients" was retained.

Table 7

Association between the Selected Demographic Variables and the Level of Self-Esteem in the Control and Experimental Group of Alcoholic Patients Before and After AST

Demographic Variables	Control Group (n=30) Before AST			Control Group (n=30) After AST			Experimental Group (n=30) Before AST			Experimental Group (n=30) After AST		
	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2
Age (in years)												
≤ 40	9	8	0.71	8	9	0.62	8	9	0.94	5	12	0.87
> 40	4	9	(df =1)	8	5	(df =1)	3	10	(df =1)	6	7	(df =1)
Educational status												
Graduates and above	6	8	0.01	8	6	0.15	5	6	1.51	7	4	1.08
Others	7	9	(df =1)	8	8	(df =1)	13	6	(df =1)	7	12	(df =1)
Occupation												
Unemployed & labourers	9	3	2.73	9	3	2.73	8	6	0.003	9	5	0.20
Employed	8	10	(df =1)	8	10	(df =1)	9	7	(df =1)	9	7	(df =1)
Marital status												
Married	6	7	0.08	7	6	0.003	8	12	0.02	8	12	0.02
Others	7	10	(df =1)	9	8	(df =1)	3	7	(df =1)	3	7	(df =1)
Monthly family income (in Rs.)												
≤ 10,000	6	5	0.03	6	5	0.03	11	6	1.04	16	1	1.90
> 10,000	11	8	(df =1)	11	8	(df =1)	6	7	(df =1)	2	11	(df =1)
Religion												
Hindu	9	10	0.04	11	8	0.03	7	11	0.006	9	9	2.16
Others	4	7	(df =1)	6	5	(df =1)	4	8	(df =1)	2	10	(df =1)
Type of the family												
Nuclear	8	12	0.27	11	9	0.07	4	12	1.08	5	11	0.44
Others	5	5	(df =1)	5	5	(df =1)	7	7	(df =1)	6	8	(df =1)
Family history of alcohol abuse/ dependence												
Yes	7	10	0.04	10	9	0.01	6	14	1.14	9	11	0.88
No	4	9	(df =1)	6	5	(df =1)	5	5	(df =1)	2	8	(df =1)

*p < 0.05.

Note: Categories under the variables were clubbed for the sake of chi-square analysis.

It could be inferred from the table 7 that there is significant no association between selected demographic variables and the level of self-esteem ($p > 0.05$). Hence the null hypothesis Ho_3 "There will be no significant association between the selected demographic variables and the level of self-esteem before and after assertiveness training among control and experimental group of alcoholic patients" was retained.

Table 8

Association between the Selected Clinical Variables and the Level of Assertiveness Skills in the Control and Experimental Group of Alcoholic Patients Before and After AST

Clinical Variables	Control Group (n=30)						Experimental Group (n=30)					
	Before AST			After AST			Before AST			After AST		
	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2
Age at which the alcohol consumption was started (in years)												
≤ 20	10	7	0.07	9	8	0.22	10	7	0.07	9	8	0.22
> 20	7	6	(df =1)	8	5	(df =1)	7	6	(df =1)	8	5	(df =1)
Duration of alcohol dependence (in years)												
≤ 10	9	10	1.83	9	10	0.74	9	2	2.55	7	4	1.29
> 10	8	3	(df =1)	7	4	(df =1)	10	9	(df =1)	8	11	(df =1)
Frequency of alcohol consumption												
Everyday	12	8	0.27	12	8	0.27	11	7	0.09	7	11	2.22
Others	5	5	(df =1)	5	5	(df =1)	8	4	(df =1)	8	4	(df =1)
Amount of alcohol consumed in a day (in ml)												
≤ 500	13	12	1.33	13	12	1.33	11	8	0.66	7	11	2.22
> 500	4	1	(df =1)	4	1	(df =1)	8	3	(df =1)	8	4	(df =1)
Money spent on alcohol consumption per day (in Rs.)												
≤ 250	7	10	1.22	5	9	3.28	10	5	0.62	9	6	1.2
> 250	8	5	(df =1)	11	5	(df =1)	9	6	(df =1)	6	9	(df =1)

Efforts to quit or cut down alcohol in the past												
Yes	15	8	0.15	12	11	0.19	15	13	1.64	15	13	1.64
No	4	3	(df =1)	3	4	(df =1)	2	0	(df =1)	2	0	(df =1)
Previous history of alcoholics de-addiction Treatment												
Yes	11	11	1.49	12	10	0.15	15	6	1.98	11	10	0.16
No	6	2	(df =1)	5	3	(df =1)	4	5	(df =1)	4	5	(df =1)
Belief in effectiveness of alcohol de-addiction treatment in dealing with addiction												
Yes	12	13	-	12	13	-	15	6	1.98	11	10	0.16
No	5	0	(df =1)	5	0	(df =1)	4	5	(df =1)	4	5	(df =1)
History of psychiatric hospitalisation												
Yes	7	3	1.09	7	3	1.09	6	1	1.97	5	2	1.68
No	10	10	(df =1)	10	10	(df =1)	13	10	(df =1)	10	13	(df =1)

*$p < 0.05$.

Note: Categories under the variables were clubbed for the sake of chi-square analysis.

It could be inferred from the table 8 that there is no significant association between selected clinical variables and the level of assertiveness skills ($p > 0.05$). Hence the null hypothesis Ho_4 "There will be no significant association between the selected clinical variables and the level of assertiveness skills before and after assertiveness training among control and experimental group of alcoholic patients" was retained.

Table 9

Association between the Selected Clinical Variables and the Level of Self-Esteem in the Control and Experimental Group of Alcoholic Patients Before and After AST

Clinical Variables	Control Group (n=30)						Experimental Group (n=30)					
	Before AST			After AST			Before AST			After AST		
	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2
Age at which the alcohol consumption was started (in years)												
≤ 20	8	10	0.02	8	10	0.68	7	11	0.01	6	12	0.22
> 20	5	7	(df =1)	8	4	(df =1)	4	8	(df =1)	5	7	(df =1)
Duration of alcohol dependence (in years)												
≤ 10	14	5	**6.49***	14	5	**6.49***	9	2	**4.48***	8	10	1.17
> 10	3	8	(df =1)	3	8	(df =1)	8	11	(df =1)	3	9	(df =1)
Frequency of alcohol consumption												
Everyday	9	10	0.04	11	8	0.03	7	11	0.006	9	9	2.16
Others	4	7	(df =1)	6	5	(df =1)	4	8	(df =1)	2	10	(df =1)
Amount of alcohol consumed in a day (in ml)												
≤ 500	10	10	0.42	11	9	0.07	7	12	1.33	5	14	2.39
> 500	3	7	(df =1)	5	5	(df =1)	4	7	(df =1)	6	5	(df =1)
Money spent on alcohol consumption per day (in Rs.)												
≤ 250	8	7	0.14	9	6	-	8	7	0.14	11	4	2.20
> 250	9	6	(df =1)	9	6	(df =1)	9	6	(df =1)	7	8	(df =1)
Efforts to quit or cut down alcohol in the past												
Yes	0	2	-	1	1	0.29	2	5	0.004	1	6	0.92
No	13	15	(df =1)	16	12	(df =1)	9	14	(df =1)	10	3	(df =1)

Previous history of alcoholics de-addiction treatment												
Yes	10	12	0.001	9	13	3.41	7	14	0.03	6	13	0.03
No	3	5	(df =1)	7	1	(df =1)	4	5	(df =1)	3	8	(df =1)
Belief in effectiveness of alcohol de-addiction treatment in dealing with addiction												
Yes	12	13	0.44	15	10	1.32	9	13	0.14	9	13	0.14
No	1	4	(df =1)	1	4	(df =1)	2	6	(df =1)	2	6	(df =1)
History of psychiatric hospitalisation												
Yes	5	5	0.27	5	5	0.07	6	1	1.31	4	3	0.03
No	8	12	(df =1)	11	9	(df =1)	12	11	(df =1)	10	13	(df =1)

*$p < 0.05$.

Note: Categories under the variables were clubbed for the sake of chi-square analysis.

It could be inferred from the table 9 that there is a significant association between duration of alcohol dependence and level of self-esteem ($p<0.05$). Hence the null hypothesis Ho_5 "There will be no significant association between duration of alcohol dependence and the level of self-esteem before and after assertiveness training among control and experimental group of alcoholic patients" was rejected.

However there is no significant association between other clinical variables like age at which the alcohol consumption was started, frequency, amount of alcohol consumption, money spent on alcohol consumption, efforts to quit alcohol in the past, previous history of alcohol de-addiction treatment, belief in effectiveness of de-addiction treatment, history of psychiatric hospitalisation and the level of self-esteem ($p > 0.05$). In this regard, the null hypothesis Ho_5 "There will be no significant association between the selected clinical variables such as age at which the alcohol

consumption was started, frequency, amount of alcohol consumption, money spent on alcohol consumption, efforts to quit alcohol in the past, previous history of alcohol de-addiction treatment, belief in effectiveness of de-addiction treatment, history of psychiatric hospitalisation and the level of self-esteem before and after assertiveness training among control and experimental group of alcoholic patients" was retained.

Summary

This chapter has dealt with the analysis and interpretation of the data obtained by the researcher. The analysis of the results showed that the level of self-esteem and assertiveness skills was increased after assertiveness training when compared to before the administration. This can be credited to the effectiveness of assertiveness training.

CHAPTER - V

DISCUSSION

Data relevant to the research findings were presented in Chapter IV. Discussion of these results and their implications are presented in two sections: an investigation of the data regarding the research hypotheses is followed by a presentation of the implications for further research.

Statement of the Problem

A Quasi Experimental Study was conducted to Assess the Effectiveness of Assertiveness Training on Assertiveness Skills and Self-Esteem among Alcoholic Patients in Selected De-Addiction Centers at Chennai.

Objectives of the Study

1. To assess the level of assertiveness skills and self-esteem in the control and experimental group of alcoholic patients.

2. To evaluate the effectiveness of assertiveness training by comparing the assertiveness skills and self-esteem of control and experimental group of alcoholic patients before and after the assertiveness training.

3. To determine the level of satisfaction among experimental group of alcoholic patients on assertiveness training.

4. To find out the association between the selected demographic variables and level of assertiveness skills and self esteem, before and after assertiveness training in the control and experimental group of alcoholic patients.

5. To find out the association between the selected clinical variables and level of assertiveness skills and self-esteem, before and after assertiveness training in the control and experimental group of alcoholic patients.

A total of 60 alcoholic patients were chosen to participate in the study from selected de-addiction centres at Chennai. The level of assertiveness skills and self-esteem was assessed before and after assertiveness training in the control and experimental groups.

The discussion is presented as follows:

- Demographic variables of the alcoholic patients.
- Clinical variables of the alcoholic patients.
- Level of assertiveness skills and self-esteem in the control and experimental group of alcoholic patients.
- Effectiveness of assertiveness training on assertiveness skills and self-esteem among alcoholic patients.
- Level of satisfaction of the alcoholic patients on assertiveness training among alcoholic patients.
- Association between the selected demographic and the level of assertiveness skills of alcoholic patients.
- Association between the selected demographic and the level of self-esteem of alcoholic patients.
- Association between the selected clinical variables and the level of assertiveness skills of alcoholic patients.

- Association between the selected clinical variables and the level of self-esteem of alcoholic patients.

Demographic variables of the alcoholic patients

In the present study, a significant percentage of the alcoholic patients were in the age group of 20-30 years (30%, 53.33%), were graduates (46.67%, 36.67%), were labourers (26.67%, 43.33%), earned a monthly family income of ≤ 10,000 rupees (36.67%, 53.33%), had two children (46.15%, 43.75%), belonged to joint family (43.33%, 50%), had a family history of alcohol abuse/ dependence (63.33%, 66.67%) in the control and experimental group respectively. Majority of them were Hindus (70%, 86.67%) in the control and experimental group respectively. Most of them were unmarried in the control group (53.13 %) and married in the experimental group (66.67%) respectively.

It was interpreted that alcoholism was more common in the age group of 20-30 years. It is true that this age represents the most productive period of one's life where the individuals destiny is determined. The result emphasizes the need of nurses to impart education to people from the school age itself about the ill effects of alcoholism. The decline in alcohol use can occur when parents start talking to their kids about risks of alcohol use and the kids were exposed to anti-alcohol messages in the media. Concerning educational status, it implies the fact that since educated people are more aware of treatment facilities of alcohol de-addiction, they are motivated and tends to come for treatment, than their counterparts.

Occupational status signifies the physical pain, stress and fatigue associated with the work of labourers. Psychiatric nurses can educate them about stress management and relaxation measures in the work place to relieve from work pressures. Employee

education programmes should highlight the impact of alcohol and other drug use on health and safety. Educational campaigns should also serve to inform employees about workplace alcohol/drug policies and procedures.

With regard to monthly income, the results reflect that alcoholism is more common among alcoholic patients who belong to low socio economic status. This finding may be due to various factors like illiteracy and lack of awareness regarding ill effects of alcoholism associated with poor socio-economic status. In general, lower socioeconomic status is related to lower health status and a shorter life expectancy. The study's findings are important to plan alcohol education programs to target people who belong to low socioeconomic status with additional information on prevention education.

While looking into the marital status and number of children of alcoholic patients, marriage and family counselling sessions can help with the tensions created in the alcoholic's home. School counsellors can provide information and support to adolescents who have family problems because of parental alcoholism. The family members should be helped to understand that they are not responsible for an alcoholic's drinking problems and should be helped to find a recovery to the problem. Moreover type of the family, points out to the fact that joint family system is still widely accepted in India, even though there is a slight decline in the present era. It also highlights the importance for the Psychiatric nurse to concentrate more on counselling sessions for the entire family in joint sessions and stress the importance of family support in rehabilitation.

Positive family history of alcohol abuse/ dependence, suggests the role of genetics in the pattern of alcohol use. Parental alcoholism may affect the foetus even before the child is born. Families of alcoholics need treatment just as much as

alcoholics. Alcohol affects each member of the family – from the unborn child to the alcoholic's spouse. Parental alcoholism may also affect the foetus even before a child is born. The results also hint the role of childhood environment whereby children adopt characteristics of important caregivers and role models as they grow up. Therefore parents should also be informed about not use alcohol in front of their children.

Regarding religion, the study finding perhaps points out the fact that Hinduism has the largest following in India. Drinking alcohol is permitted during Hindu festivals, marriages and family celebrations. Many religious rituals and ceremonies permit alcohol usage in Hinduism. However, in the Hindu scriptures drinking is referred to as one of the five heinous crimes. Alcohol abuse is less likely when it is prohibited on religious grounds.

Clinical variables of the alcoholic patients

In the present study most of the alcoholic patients in the control and experimental group started consuming alcohol at the age of ≤ 20 years (50%, 56.67%), for a duration of ≤ 10 years (46.67%, 36.67%), stated enjoyment/ pleasure as the precipitating factor for alcohol consumption (73.33%, 66.67%), tolerance as the situation that provoked them to consume more amount of alcohol (63.33%, 63.33%), consumed alcohol everyday (57%, 60%), had tremors in hands and fingers (60%, 66.67%), had a previous history of alcohol de-addiction treatment (73.33%, 70%), believed in alcohol de-addiction treatment to be effective (83.33%, 73.33%) and stated family responsibility as the motivation to seek treatment (73.33%, 60%) respectively.

Majority of them made an effort to quit or cut down alcohol in the past (93.33%, 76.67) and were abstinent (100%, 100%) at least once for a brief period in the control and experimental group respectively. A significant percentage of them consumed an

amount of ≤ 250 ml per day (30%, 30%), spent an amount of ≤ 250 rupees (50%, 50%), developed complications like depression (26.67%, 40%), stated self-control as the reason for abstinence (21.43%, 17.39%), stated loss of pleasure as the reason for restarting alcohol consumption after a period of abstinence (39.29%, 60.87%), had a history of psychiatric hospitalisation (33.33%, 23.33%) and stated depression as the reason for psychiatric hospitalisation (30%, 57.14) in the control and experimental group respectively.

The age of onset possibly indicates factors like peer pressure, curiosity, risk taking and novelty seeking traits associated with adolescence. Also adolescence is a period during which increased socialisation takes place. Psychiatric nurses can teach negative assertion techniques to this population which would help them to resist peer pressures. Dependency for a period of less than 10 years may be probably because of awareness in the midst of patients about the importance of seeking treatment. This would be the right time for health education as chronic drinking pattern may end up in life threatening complications.

Enjoyment/pleasure as the precipitating factor for alcohol hints the fact that the pattern of drinking in India is undergoing a change from being an occasional and ritualistic use to a social event. Today the most common purpose of consuming alcohol is to get drunk. However, Psychiatric nurses should make alcoholic patients to be aware about the gap that exists between social drinking and problem drinking. Experiencing tremors in hands and fingers hints that the alcoholic patients are in a withdrawal state. Alcoholic patients should be educated about disulfiram therapy, the management of withdrawal symptoms and the complications of taking alcohol when on disulfiram therapy.

Drinking alcohol everyday reflects the culture of heavy daily drinking among lower and lower-middle sections of the society in Chennai, where working class men assemble around liquor shops every evening and enjoy drinking and socializing. Brandy was used predominantly. A point of interest was that frequent beer drinkers were a minority in this population. This may be related to the high price of beer, compared with spirits for equivalent amounts of absolute alcohol. Amount of alcohol consumed and money spent on alcohol signifies the importance given to drinking over other interests. When the Psychiatric Nurse discusses the dangers of alcoholism over the beneficial effects, it may change the attitude of an alcoholic towards drinking.

Most of the alcoholic patients depleted their own earning to buy alcohol. This finding may be endorsed to the fact that due to its large population India has been identified as the largest market for alcoholic beverages in the world which has attracted the attention of multi national liquor companies. Taxes generated from alcohol production and sale is the major source of revenue in most states and has been cited as the reason for permitting alcohol use. History of tobacco smoking along with alcohol indicates the nurses need to educate public also about quitting other drugs. Drug cessation programs should target high risk population like school children, college students, army men and labourers. Regarding conflicts in relationships, nurses should take one step ahead and reach the family members especially the wives of alcoholics. Domestic violence and its prevention strategies can be taught. Moreover conflict management strategies a component of assertiveness training can be taught to alcoholic patients.

Developing depression as a complication should be dealt with aspects of assertiveness training like positive thinking and self-esteem improvement strategies. Psychiatric nurses should teach alcoholic patients about the warning signs of depression

and the importance of seeking early psychiatric treatment. Self-control as the reason for abstinence signifies the importance of motivation in de-addiction treatment. Alcoholic patients should be empowered with assertive strategies in order to prevent relapse. Assertiveness training should be a necessary ingredient of de-addiction program. Nurses at the basic level should be equipped with assertive skills just like giving an injection. Loss of pleasure was stated as the reason of abstinence. This highlights the need of nurses to teach them about positive coping strategies. They should be encouraged to look into the positive aspects of life instead of ruminating over the past.

Level of assertiveness skills and self-esteem in the control and experimental group of alcoholic patients

Majority of the alcoholic patients in the control group were non-assertive and had normal level of self-esteem before (96.7%, 70%) and after (96.67%, 80%) AST respectively. None of them had high self-esteem. In the experimental group, most of the alcoholic patients were non-assertive and had normal level of self-esteem before AST (93.3%, 70%). However, after the administration of AST, most of them were assertive (63.3%) and majority of them had normal level of self-esteem (76.67%) in the experimental group of alcoholic patients respectively. Twenty percent of them had high self- esteem after AST. This can be ascribed to the effectiveness of AST.

Effectiveness of assertiveness training on assertiveness skills and self-esteem among alcoholic patients

The mean and standard deviation for scores of assertiveness skills (M=-2.47, SD=12.78), (M=-3.30, SD=12.25) and self-esteem (M=16.93, SD=3.52), (M=15.7, SD=4.25) among alcoholic patients before AST in the control and experimental group was not significant at $p>0.05$. On the other hand, after the

administration of AST, the mean and standard deviation of assertiveness skills (M=2.60, SD=13.34) and self-esteem (M=17.37, SD=3.06) of control group were less in comparison with the assertiveness skills (M=24.83, SD=9.56) and self-esteem (M=21.9, SD=3.54) scores of experimental group. The difference was found statistically significant at $p<0.001$ level of confidence and it can be accredited to the effectiveness of AST. Hence the null hypothesis Ho_1 was rejected.

Ferrell. W. L., & Galassi. J. P., (1981) compared the effects of milieu therapy plus assertion training to milieu therapy plus human relations training in reducing drinking behaviour and increasing interpersonal skills, of skill-deficient, chronic alcoholics in an alcoholic rehabilitation centre. Although both treatments led to comparable sobriety rates at a 6-week follow-up, the treatment group which contained assertion training demonstrated significant gains in interpersonal skills as compared to the treatment group which contained human relations training. A two year sobriety was achieved which was significantly longer than the human relations training group.

Being assertive is something what a confident person does naturally. Learning to act and speak in a more assertive way could help to overcome several obstacles in life such as shyness, low self esteem and a lack of confidence. An assertive person will be confident to stand up and be counted, put an opinion forward and stand by it. He/she will not be quiet and go ignored. Being assertive is all about bringing respect for oneself. This will also reflect outwards as one will begin to respect others as having equal rights as him. Simply put, assertiveness is asking for what you want or speaking up for yourself when you feel strongly that you have something to say.

In 1975, the U.S. psychologist Robert P. Liberman introduced assertion or personal effectiveness training as a fundamental component of the clinical services offered by community health centres'. Since then, the evidence collected has established

the effectiveness of structured learning and behaviour modification that occurs within groups. Such training, which is broadly termed as Assertiveness Training, is an important part of any form of behaviour therapy.

Level of satisfaction of the alcoholic patients on assertiveness training among alcoholic patients

The level of satisfaction of assertiveness training indicated from the analysis that the majority of alcoholic patients had a high level of satisfaction on training program. Ninety three percent were highly satisfied, the rest showed the second level of satisfaction as just satisfied and none of them were dissatisfied or highly dissatisfied.

The alcoholic patients felt and expressed that the training program provided was relevant and useful to their routine interactions and they were confident to apply these skills in day to day activities. Moreover, the participants were satisfied as their goals and expectations were met during the training program. It is worth noting that subjects felt the need to conduct such programs for all alcoholic patients.

Thus the present assertiveness training program was found to be effective not only from a statistical point of view but also from the feed back and evaluation provided by the participants.

Association between the selected demographic variables and the level of assertiveness skills of alcoholic patients

Chi square test was used to find out the association between selected demographic and level of assertiveness skills. It was found that there was a significant association between age of the alcoholic patients (χ^2=4.85, df=1) at $p<0.05$ and the level

of assertiveness skills. Hence the null hypothesis Ho_2 with regard to association between age and assertiveness skills was rejected.

The study finding indicates that as age increases assertiveness skills also increases. With increasing age, the individual learns interpersonal skills which in turn increases his/her feelings of confidence in interpersonal situations. The individual may feel more in control of their lives. With the feelings of self-efficacy the individual responds assertively in interaction with others. Older individuals may exhibit assertive behaviour as a result of coping with major social changes of life. This finding is consistent with a study conducted on five pivotal personality traits on pairs of twins: empathy, nurturance, aggressiveness, assertiveness and, of course, altruism. The author administered tests designed for evaluating each trait and scored them. Results of the study showed that all of the "positive" traits (empathy, nurturance, altruism, and assertiveness) increased with age, whereas aggressiveness decreased with age (Rushton et al., 1986).

However there is no significant association between other demographic variables like educational status, occupation, marital status, monthly family income, religion, type of the family, family history of alcohol abuse/ dependence and the level of assertiveness skills ($p > 0.05$). In this regard, the null hypothesis Ho_2 with regard to association between other demographic variables such as educational status, occupation, marital status, monthly family income, and religion, type of the family, family history of alcohol abuse / dependence and the level of assertiveness skills was retained.

Association between the selected demographic variables and the level of self-esteem of alcoholic patients

It was found that there was no significant association between the selected demographic variables and the level of self-esteem in the control and experimental group of alcoholic patients. Hence the null hypothesis Ho_3 was retained. It could be inferred that irrespective of the demographic variables, level of self-esteem was low and assertiveness training can be administered to all the alcoholic patients.

Association between the selected clinical variables and the level of assertiveness skills of alcoholic patients

It was found that there was no significant association between the selected clinical variables and the level of assertiveness skills in the control and experimental group of alcoholic patients. Hence the null hypothesis Ho_4 was retained. It could be inferred that irrespective of the clinical variables, level of assertiveness skills was low and assertiveness training can be administered to all the alcoholic patients.

Association between the selected clinical variables and the level of self-esteem of alcoholic patients

It was found that there was a significant association between duration of alcohol dependence and the level of self-esteem (χ^2=6.49, df=1; χ^2=4.48, df=1) at $p<0.05$. Hence the null hypothesis Ho_5 with regard to association between duration of alcohol dependence and self-esteem was rejected.

The findings indicate that self-esteem was low among patients who consumed alcohol for a period of ≤ 10 years compared to their counterparts. This perhaps reflects the guilt and inadequacy associated with excessive drinking for a prolonged period of

time. This would in turn result in self-esteem disturbances as the drinker becomes gradually less capable of functioning as a parent, spouse, and a bread winner of the family. The nurses should incorporate assertiveness training program to enhance the self-esteem of alcoholic patients as a routine treatment in de-addiction. This would possibly prevent relapse in future. Similar findings are reported in a prospective study of self-esteem and alcohol use disorders in early adulthood. The results indicated that women who had an alcohol use disorder for 3-4 years showed relatively low levels of self-esteem (Walitzer et al., 1996).

However there is no significant association between other clinical variables like age at which the alcohol consumption was started, frequency, amount of alcohol consumption, money spent on alcohol consumption, efforts to quit alcohol in the past, previous history of alcohol de-addiction treatment, belief in effectiveness of de-addiction treatment, history of psychiatric hospitalisation and the level of self-esteem ($p > 0.05$). In this regard, the null hypothesis Ho_5 with regard to association between other selected clinical variables such as age at which the alcohol consumption was started, frequency, amount of alcohol consumption, money spent on alcohol consumption, efforts to quit alcohol in the past, previous history of alcohol de-addiction treatment, belief in effectiveness of de-addiction treatment, history of psychiatric hospitalisation and the level of self-esteem was retained.

Summary

This chapter has dealt with the objectives of the study, major findings of the demographic and clinical variables, level of assertiveness skills and self-esteem of alcoholic patients before and after assertiveness training, association between selected demographic variables, clinical variables and the level of assertiveness skills and self-esteem and the level of satisfaction on assertiveness training.

CHAPTER - VI

SUMMARY, CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

This is the most ingenious and demanding part of the study. This chapter gives a brief account of the present study including the conclusion drawn from the finding, recommendations, limitations of the study, suggestions for the study and nursing implications.

Summary

A Quasi Experimental Study was conducted to Assess the Effectiveness of Assertiveness Training on Assertiveness Skills and Self-Esteem among Alcoholic Patients in Selected De-Addiction Centers at Chennai.

Objectives of the Study

1. To assess the level of assertiveness skills and self-esteem in the control and experimental group of alcoholic patients.

2. To evaluate the effectiveness of assertiveness training by comparing the assertiveness skills and self-esteem of control and experimental group of alcoholic patients before and after the assertiveness training.

3. To determine the level of satisfaction among experimental group of alcoholic patients on assertiveness training.

4. To find out the association between the selected demographic variables and level of assertiveness skills and self esteem, before and after assertiveness training in the control and experimental group of alcoholic patients.

5. To find out the association between the selected clinical variables and level of assertiveness skills and self-esteem, before and after assertiveness training in the control and experimental group of alcoholic patients.

Null Hypotheses

Ho_1: There will be no significant difference in the level of assertiveness skills and self-esteem before and after assertiveness training in the control and experimental group of alcoholic patients.

Ho_2: There will be no significant association between the selected demographic variables and the level of assertiveness skills and self-esteem before and after assertiveness training in the control and experimental group of alcoholic patients.

Ho_3: There will be no significant association between the selected demographic variables and the level of self-esteem before and after assertiveness training in the control and experimental group of alcoholic patients.

Ho_4: There will be no significant association between the selected clinical variables and the level of assertiveness skills before and after assertiveness training in the control and experimental group of alcoholic patients.

Ho_5: There will be no significant association between the selected clinical variables and the level of self-esteem before and after assertiveness training in the control and experimental group of alcoholic patients.

A quasi experimental research deign was selected to achieve the objectives of the study. The study was conducted at Freedom care and foundation, Sithalapakkam and Wisdom hospitals, Saidapet. Samples were selected using purposive sampling technique. Sixty alcoholic patients were selected and randomization of the settings was done. Out of which, 30 alcoholic patients were assigned to the control group and 30 clients were assigned to the experimental group.

The conceptual framework of the study was developed on the basis of Peplau's interpersonal theory (1952) given by Dr. Hildegarde Peplau. An extensive review of literature and the guidance by experts found the foundation to the development of the tool. The investigator used a demographic variable proforma of alcoholic patients, clinical variable proforma of alcoholic patients, Rathus assertiveness schedule, Rosenberg self-esteem scale and a rating scale on the level of satisfaction of assertiveness training among alcoholic patients to collect the data. The data collection tools were validated and reliability was established. After the pilot study the data for the main study was collected. Assertiveness training was given in the experimental group for a period of ten days, 1 hour session per day. The level of assertiveness skills and self-esteem scores was assessed for both the control and the experimental group before and after the intervention. The collected data was tabulated and analyzed using descriptive and inferential statistics.

Major Findings of the Study

Demographic variables of the alcoholic patients

In the present study, a significant percentage of the alcoholic patients were in the age group of 20-30 years (30%, 53.33%), were graduates (46.67%, 36.67%), were labourers (26.67%, 43.33%), earned a monthly family income of ≤ 10,000 rupees

(36.67%, 53.33%), had two children (46.15%, 43.75%), belonged to joint family (43.33%, 50%), had a family history of alcohol abuse/ dependence (63.33%, 66.67%) in the control and experimental group respectively. Majority of them were Hindus (70%, 86.67%) in the control and experimental group respectively. Most of them were unmarried in the control group (53.13%) and married in the experimental group (66.67%) respectively.

Clinical variables of the alcoholic patients

In the present study most of the alcoholic patients in the control and experimental group started consuming alcohol at the age of ≤ 20 years (50%, 56.67%), for a duration of ≤ 10 years (46.67%, 36.67%), stated enjoyment/ pleasure as the precipitating factor for alcohol consumption (73.33%, 66.67%), tolerance as the situation that provoked them to consume more amount of alcohol (63.33%, 63.33%), consumed alcohol everyday (57%, 60%), had tremors in hands and fingers (60%, 66.67%), had a previous history of alcohol de-addiction treatment (73.33%, 70%), believed in alcohol de-addiction treatment to be effective (83.33%, 73.33%) and stated family responsibility as the motivation to seek treatment (73.33%, 60%) respectively.

Majority of them made an effort to quit or cut down alcohol in the past (93.33%, 76.67) and were abstinent (100%, 100%) at least once for a brief period in the control and experimental group respectively. A significant percentage of them consumed an amount of ≤ 250 ml per day (30%, 30%), spent an amount of ≤ 250 rupees (50%, 50%), developed complications like depression (26.67%, 40%), stated self-control as the reason for abstinence (21.43%, 17.39%), stated loss of pleasure as the reason for restarting alcohol consumption after a period of abstinence (39.29%, 60.87%), had a history of psychiatric hospitalisation (33.33%, 23.33%) and

stated depression as the reason for psychiatric hospitalisation (30%, 57.14) in the control and experimental group respectively.

Level of assertiveness skills and self-esteem of alcoholic patients before and after assertiveness training

Majority of the alcoholic patients in the control group were non-assertive and had normal level of self-esteem before (96.7%, 70%) and after (96.67%, 80%) AST respectively. None of them had high self-esteem. In the experimental group, most of the alcoholic patients were non-assertive and had normal level of self-esteem before AST (93.3%, 70%). However, after the administration of AST, most of them were assertive (63.3%) and majority of them had normal level of self-esteem (76.67%) in the experimental group of alcoholic patients respectively. Twenty percent of them had high self- esteem after AST. This can be ascribed to the effectiveness of AST.

Mean and standard deviation for scores of assertiveness skills and self-esteem of alcoholic patients before and after assertiveness training

The mean and standard deviation for scores of assertiveness skills (M=-2.47, SD=12.78), (M=-3.30, SD=12.25) and self-esteem (M=16.93, SD=3.52), (M=15.7, SD=4.25) among alcoholic patients before AST in the control and experimental group was not significant at $p>0.05$. On the other hand, after the administration of AST, the mean and standard deviation of assertiveness skills (M=2.60, SD=13.34) and self-esteem (M=17.37, SD=3.06) of control group were less in comparison with the assertiveness skills (M=24.83, SD=9.56) and self-esteem (M=21.9, SD=3.54) scores of experimental group. The difference was found statistically significant at $p<0.001$ level of confidence and it can be accredited to the effectiveness of AST. Hence the null hypothesis Ho_1 was rejected.

Level of satisfaction on assertiveness training among alcoholic patients

The percentage distribution of level of satisfaction on AST indicated that majority of the alcoholic patients were highly satisfied (93.33%).

Association between the selected demographic variables and the level of assertiveness skills of alcoholic patients

Chi square test was used to find out the association between selected demographic and level of assertiveness skills. It was found that there was a significant association between selected demographic variables like age of the alcoholic patients (χ^2=4.85, df=1) at $p<0.05$ and the level of assertiveness skills. Hence the null hypothesis Ho_2 with regard to association between age and the level of assertiveness skills was rejected.

However there is no significant association between other demographic variables like educational status, occupation, marital status, monthly family income, religion, type of the family, family history of alcohol abuse/ dependence and the level of assertiveness skills ($p > 0.05$). In this regard, the null hypothesis Ho_2 with regard to association between other demographic variables such as educational status, occupation, marital status, monthly family income, and religion, type of the family, family history of alcohol abuse / dependence and the level of assertiveness skills was retained.

Association between the selected demographic variables and the level of self-esteem of alcoholic patients

It was found that there was no significant association between the selected demographic variables and the level of self-esteem in the control and experimental group of alcoholic patients. Hence the null hypothesis Ho_3 was retained.

Association between the selected clinical variables and the level of assertiveness skills of alcoholic patients

It was found that there was no significant association between the selected clinical variables and the level of assertiveness skills. Hence the null hypothesis Ho_4 was retained.

Association between the selected clinical variables and the level of self-esteem of alcoholic patients

It was found that there was a significant association between duration of alcohol dependence (χ^2=6.49, df=1; χ^2=4.48, df=1) and the level of self-esteem at $p<0.05$. Hence the null hypothesis Ho_5 with regard to association between duration of alcohol dependence and the level of self-esteem was rejected.

However there is no significant association between other clinical variables like age at which the alcohol consumption was started, frequency, amount of alcohol consumption, money spent on alcohol consumption, efforts to quit alcohol in the past, previous history of alcohol de-addiction treatment, belief in effectiveness of de-addiction treatment, history of psychiatric hospitalisation and the level of self-esteem ($p > 0.05$). In this regard, the null hypothesis Ho_5 with regard to association between the other selected clinical variables such as age at which the alcohol consumption was started, frequency, amount of alcohol consumption, money spent on alcohol consumption, efforts to quit alcohol in the past, previous history of alcohol de-addiction treatment, belief in effectiveness of de-addiction treatment, history of psychiatric hospitalisation and the level of self-esteem was retained.

Conclusion

The study revealed that the assertiveness training was effective in improving the level of assertiveness skills and self-esteem of the alcoholic patients. This study provides an excellent framework to look at how alcoholics understand and manage emotions. Assertiveness training which is a behavioural therapy intervention can be effectively utilised to help alcoholic clients achieve a greater degree of self-esteem and emotional freedom.

Implications

The implication for nursing practice, nursing education, nursing administration and nursing research are presented based on the findings.

Nursing practice

Assertiveness is considered healthy behaviour for all people that, which results in personal empowerment. Assertive behaviour among nurse practitioners is an invaluable component for successful professional practice. As nurses move away from traditional subservient roles and perceived stereotypes it is increasingly being recognised that a nurse needs to behave in an assertive manner. It may also aid the confidence of the profession as it develops. Assertiveness is necessary for effective nurse/patient communication. The results of the study clearly demonstrated that the effect of assertiveness training in enhancing assertiveness and self-esteem of patients in various settings. Nurses can also use the exercises from the current study to help patients find more assertive and empowered ways to react and be proactive.

Nursing education

The researcher's premise is that assertiveness is a skill, like giving an injection or taking a nursing history, which requires adequate and systematic practice. Assertive behaviour may be encouraged through educational methods. It is preferable that nurses receive this educational preparation during undergraduate programmes. Hence nurse educators have an important role in the development and implementation of assertiveness training/education programmes for undergraduate nursing students. The present study also encourages readers to assess and build their skills through self-study and role playing.

Nursing theory

The conceptual model exclusively for the use of assertiveness training is to be developed by nursing theorist. The path analysis used to identify the determinant of low assertiveness skills and self esteem in alcoholic patients is presented in the present study in the form of conceptual model which can be used to educate and guide the nurses in caring for alcoholic patients.

Nursing administration

The nursing profession must be more assertive in its need to be heard. Assertiveness behaviour is an important quality that helps to safeguard the interest of nursing staff and enhances the dignity of the nursing profession. It is a learned interpersonal communication skill that helps to communicate one’s professional position, confirm one’s needs, express opinions, avoids judgment errors firmly and sustains an appropriate degree of independent authority necessary to uphold the rights and dignity of nurses. Assertiveness training program should be a part of the staff-development programs for nurses.

Nursing research

There is a need for extensive research in this area. It opens a big avenue for research as quality and cost-effectiveness so as to generate more scientific data. Encourage further studies on effectiveness of assertiveness training in enhancing the assertiveness level. Disseminate the findings via conferences, seminars, publications, in professional, national, international journals and world wide website

Recommendations

- The study can be conducted on a large scale to generalize the results.
- The study can be conducted among different groups like adolescents, mentally ill patients, teenagers who abuse other substances, family members of alcoholic patients etc.
- A follow up study can be conducted to assess the effectiveness of the present programme in reducing the relapse rates of alcoholic patients.
- A time series design can be conducted with an interval of 2, 4 and 6 months to assess the long term effects of assertiveness training upon assertiveness skills and self-esteem.
- A study can be conducted on quality of life among alcoholic patients.

Limitations

- The study findings cannot be generalised due to small sample size.
- Random sampling was not possible due to practical difficulties.
- True experimental research could not be conducted as there are chances of contamination effects.

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APPENDIX - I

LETTER SEEKING PERMISSION TO CONDUCT THE STUDY

Apollo College of Nursing

(Recognised by the Indian Nursing Council and Affiliated to the Tamil Nadu Dr. M.G.R. Medical University, Chennai)

CO/1015/11 **13.06.2011**

To

The Director
Freedom Foundation/Rehabilitation Centre
No: 3 C, Dhandeeswaram Main Road,
Near Sumangali Silks,
Velacheri,
Chennai - 600042

Respected Sir / Madam,

Sub. : To request permission for research – Reg.

Greetings! As a part of the curriculum requirement, our II year M.Sc. (N) student Ms. Jyothi. S. Sunandha has selected the following title for her research study.

"An Experimental Study to assess the Effectiveness of Assertiveness Training on Assertiveness and Self – Esteem of Alcoholic Patients in selected De-addiction Centres, Chennai".

So I kindly request your good selves to permit her to conduct research in your esteemed institution and use the resource materials for the above –mentioned candidate.

Thanking You,

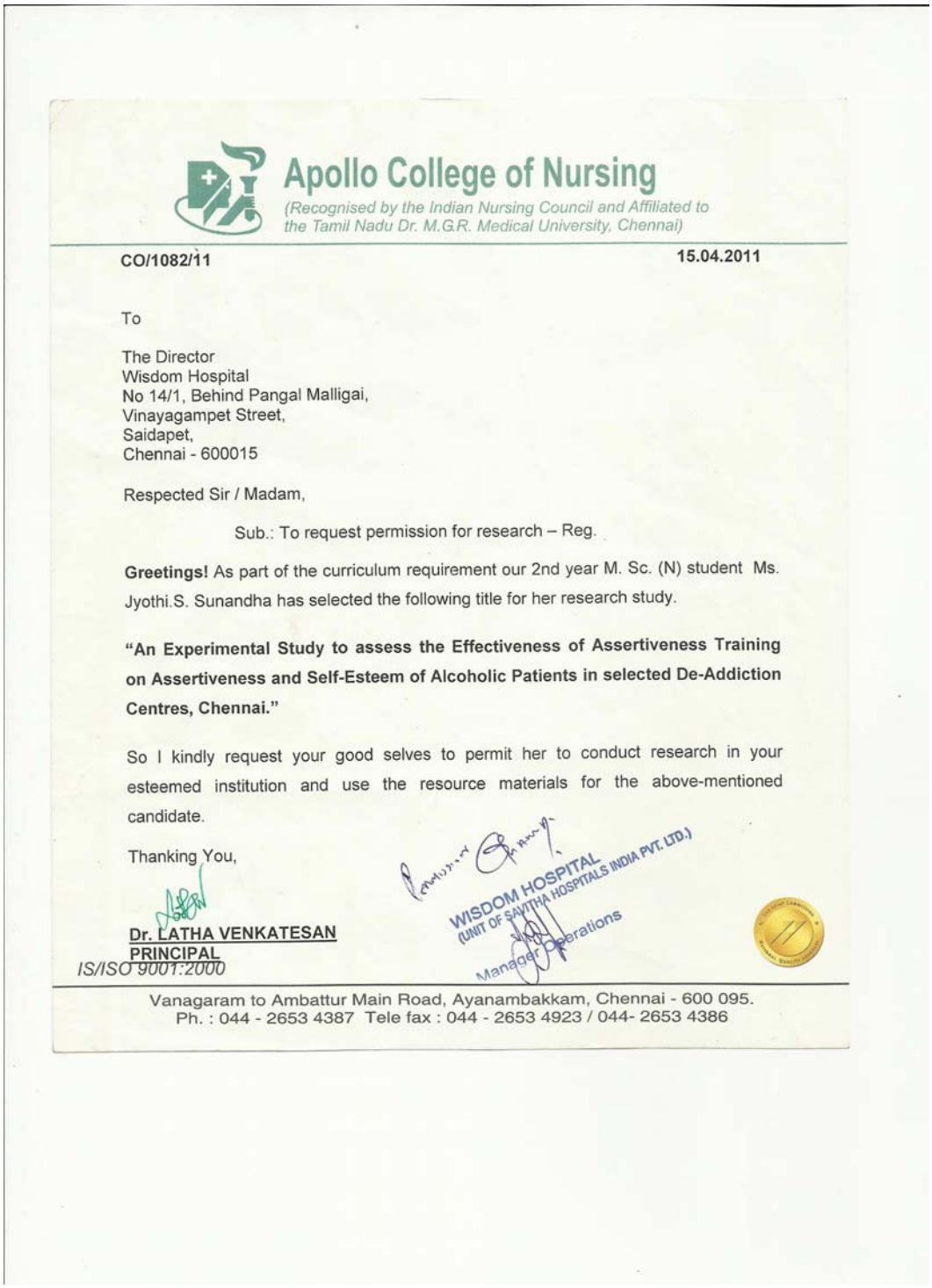
Dr.LATHA VENKATESAN
PRINCIPAL

19/6/11

IS/ISO 9001:2000

Vanagaram to Ambattur Main Road, Ayanambakkam, Chennai - 600 095.
Ph. : 044 - 2653 4387 Tele fax : 044 - 2653 4923 / 044- 2653 4386

LETTER SEEKING PERMISSION TO CONDUCT THE STUDY



Apollo College of Nursing

(Recognised by the Indian Nursing Council and Affiliated to the Tamil Nadu Dr. M.G.R. Medical University, Chennai)

CO/1082/11 **15.04.2011**

To

The Director
Wisdom Hospital
No 14/1, Behind Pangal Malligai,
Vinayagampet Street,
Saidapet,
Chennai - 600015

Respected Sir / Madam,

Sub.: To request permission for research – Reg.

Greetings! As part of the curriculum requirement our 2nd year M. Sc. (N) student Ms. Jyothi.S. Sunandha has selected the following title for her research study.

"An Experimental Study to assess the Effectiveness of Assertiveness Training on Assertiveness and Self-Esteem of Alcoholic Patients in selected De-Addiction Centres, Chennai."

So I kindly request your good selves to permit her to conduct research in your esteemed institution and use the resource materials for the above-mentioned candidate.

Thanking You,

Dr. LATHA VENKATESAN
PRINCIPAL

WISDOM HOSPITAL
(UNIT OF SAVITHA HOSPITALS INDIA PVT. LTD.)
Manager Operations

IS/ISO 9001:2000

Vanagaram to Ambattur Main Road, Ayanambakkam, Chennai - 600 095.
Ph. : 044 - 2653 4387 Tele fax : 044 - 2653 4923 / 044- 2653 4386

APPENDIX - II

LETTER PERMITTING TO CONDUCT THE STUDY

Freedom care
Center for Chemical Dependancy and HIV/AIDS

To,
Dr.Latha Venkatesan
Principal
Apollo collage of Nursing
Aynambakkam
Chennai:600 095

15Th June 2011

Dear Madam,

SUB: Permission letter for conducting the study

As per your letter received to us dated 13-6-2011 as specified project study to your student Ms.Jyothi.s sunandha ,2nd year M.sc (N) has been permitted to conduct the study at Freedom Care Rehabilitation centre for chemical dependency and HIV/AIDS , w.e.f 17th June to 16th July 2011.

We confirm and acknowledge her project studies with our institution in scheduled timings with good effort.

We thank you and assuring you of our best attention to benefit the student.

Yours Truly FREEDOM CARE
K.N. Srinivasa Naraen
Chairman
Freedom Care (Chairman)

Copy to

Ms.Jyothi.s.sunandha

M.Sc (N)-2nd year student

Regd. Off: 19/3 C, Dhandesswaram Nagar Main Road, Velachery, Chennai - 600 042. Ph: 044 - 22430619
Treatment Centre: Deiva Lakshmi Illam, No.2/881, 1st Main Road, Valluvar Nagar, Sithalapakkam, Chennai-600 073. Ph: 29001160
e-mail:freedomcarechennai@gmail.com Website : www.thefreedomcare.org

LETTER PERMITTING TO CONDUCT THE STUDY

WISDOM HOSPITAL

June 15, 2011

To
The Principal,
Apollo College of Nursing,
Chennai

Ref: Your letter Ref no.CO/1082/11 dt. 15/04/11 regarding permission for Research

Dear Madam,

With reference to the above, we are glad to extend our permission for Ms.Jyothi S.Sunandha, student of II year M.Sc Nursing to do her research study in our Hospital on **"An Experimental Study to access the Efffectiveness of Assertiveness Training on Assertiveness and Self-Esteen of Alcoholic Patients in Selected De-Addiction Centres, Chennai"** from June 17,2011 to July 17,2011.

Thank you,
Warm Regards,

WISDOM HOSPITAL
(UNIT OF SAVITHA HOSPITALS INDIA PVT. LTD.)

Manager Operations

Kamalesh Jayakar

14/1 Vinayagampet Street, Saidapet, Chennai – 15, Phone: 044-24323130 / 24340916
E-mail: wisdom_hospital2002@yahoo.com
Website : www.wisdomhospital.org

APPENDIX III

LETTER SEEKING PERMISSION FOR CONTENT VALIDITY

From

Ms. Jyothi. S. Sunandha,
M.Sc., (Nursing) I Year,
Apollo College of nursing,
Chennai-600095

To

Sub: Request for opinion and suggestion of experts for establishing Content Validity of Research Tool

Respected Madam

Greetings! As a part of the Curriculum Requirement the following research title is selected for the study.

"A Quasi Experimental Study to Assess the Effectiveness of Assertiveness Training upon Assertiveness Skills and Self-Esteem among Alcoholic Patients in Selected De-Addiction Centres at Chennai."

I will be highly privileged to have your valuable suggestion with regard to the establishment of content validity of the Research Tool. I request your permission for the same and to forward the study protocol along with the instruments for validation.

Thanking you,

Yours Sincerely

(Jyothi. S. Sunandha)

APPENDIX - IV

LETTER SEEKING PERMISSION TO USE THE STUDY TOOL

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03/15/2011

Jyothi S Sunandha
Apollo College of Nursing
psychiatric nursing
vanagaram to ambattur main road
ayanambakkam
chennai, tamil nadu 600095 india

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Sincerely,

Karen Lee
Senior Grant Coordinator

LETTER SEEKING PERMISSION TO USE THE STUDY TOOL

Gmail by Google

Jyothi Sunandha <jyothi.daffs@gmail.com>

RE: requesting for acceptance

1 message

Bottger, Ray <RBottger@odmhsas.org> **Tue, Mar 15, 2011 at 4:13 AM**

To: jyothi sunandha <jyothi.daffs@gmail.com>

Jyothi, you can use the information off of the MHSIP.org website as long as you cite the source (check with your professors for the proper format). Good luck with your research!

Ray Bottger, PhD

MHSIP.org

From: jyothi sunandha [mailto:jyothi.daffs@gmail.com]
Sent: Saturday, March 12, 2011 10:32 AM
To: Bottger, Ray
Subject: reqyesting for acceptance

Dear sir

I am Jyothi. S. Sunandha, pursuing my nursing post- graduation in Apollo Educational Institute, Chennai, India.

I am doing my research in, **"Effectiveness of assertiveness training on self-esteem and assertiveness among B.Sc Nursing students"** as a part of my curriculum requirement. I have gone through your web-site and got Rosenberg Self- esteem test.pdf file. I would like to include this information in my research.

This is my humble request. Please accept this as official letter.

Thanks and regards,

Jyothi. S. Sunandha

+9171715900

APPENDIX - V

EHICS COMMITTEE CLEARANCE LETTER

Ethics Committee

Apollo HOSPITALS
TOUCHING LIVES

22 June, 2011

To

Ms. Jyothi.S.Sunandha
1st Year M.Sc (Nursing)
Dept. of Psychiatry
Apollo College of Nursing, Chennai
Tamil Nadu, India

Ref: An experimental study to assess the effectiveness of assertiveness training upon assertiveness and self-esteem among alcoholic patients in selected de-addiction centres at Chennai

Sub: Your letter dated 9 June, 2011 for approval of the above referenced project and its related documents

Dear Ms. Jyothi.S.Sunandha,

Ethics committee – Apollo Hospitals has received the following document submitted by you related to the conduct of the above – referenced study.

- Project Proposal titled "An experimental study to assess the effectiveness of assertiveness training upon assertiveness and self-esteem among alcoholic patients in selected de-addiction centers at Chennai "
- Study Performa
- Informed consent form

The above-mentioned documents have been reviewed and approved (through expedited review) by the Chairman, Vice-Chairman and Member Secretary at a specially convened meeting of the Ethics Committee. The study is hereby approved to be conducted by you in the presented form

The following Ethics Committee members were present at the meeting held on 15 June, 2011

Name	Profession	Position in the committee
Mr. S. S. Narayanan	Ethicist	Chairman
Dr.Radha Rajagopalan	Clinician	Vice - Chairman
Dr. Jayanthi Swaminathan	Sr.GM Clinical & Collaborative Research	Member Secretary

Apollo Hospitals Enterprise Limited
21, Greams Lane, Off Greams Road, Chennai - 600 006
Tel : 91 - 44 - 2829 3333 Extn : 6008, 91 - 44 - 2829 5465 Extn : 6639 Fax : 91 - 44 - 2829 4449
E - Mail : ecapollochennai@gmail.com

Ethics Committee

Apollo HOSPITALS
TOUCHING LIVES

After due ethical and scientific consideration, the Ethics Committee has approved the above presentation submitted by you.

The Ethics Committee is constituted and works as per ICH-GCP, ICMR and revised Schedule Y guidelines.

Yours sincerely,

Radhakrishnan

Date 22/6/11

Dr. Radha Rajagopalan
Ethics Committee – Vice Chairman
Apollo Hospitals, Chennai

DR. RADHA RAJAGOPALAN
Vice Chairman
Ethics Committee
Apollo Hospitals Enterprise Limited
Chennai-600 006. Tamil Nadu.

Apollo Hospitals Enterprise Limited
21, Greams Lane, Off Greams Road, Chennai - 600 006
Tel : 91 - 44 - 2829 3333 Extn : 6008, 91 - 44 - 2829 5465 Extn : 6639 Fax : 91 - 44 - 2829 4449
E - Mail : ecapollochennai@gmail.com

APPENDIX - VI

PLIAGARISM ORIGINALITY REPORT

Plagiarism Detector - Originality Report

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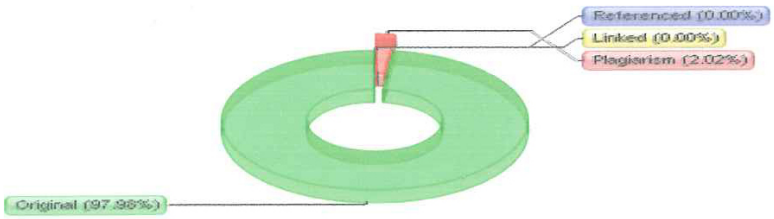

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APPENDIX - VII

CONTENT VALIDITY CERTIFICATE

I hereby certify that I have validated the research tool and interventional programme of Ms. Jyothi. S. Sunandha, M.Sc. (N) student who is undertaking research study.

A Quasi Experimental Study to Assess the Effectiveness of Assertiveness Training upon Assertiveness Skills and Self-Esteem among Alcoholic Patients in Selected De-addiction Centres at Chennai.

Signature of Expert
Name & Designation

APPENDIX - VIII

LIST OF EXPERTS FOR CONTENT VALIDATY

1. **Dr. Latha Venkatesan,**
   M.Sc (N)., M.Phil., Ph.D.,
   Principal and Professor,
   Apollo College of Nursing,
   Chennai - 600 095.

2. **Dr. Bharathi Visveswaran,**
   M.D., D.P.M., F.I.P.S.,
   Consultant Psychiatrist,
   Apollo Hospitals,
   Chennai – 600 006.

3. **Prof. Lizy Sonia. A., M.Sc (N).,**
   Vice Principal, HOD of Medical Surgical Nursing,
   Apollo College of Nursing,
   Chennai - 600 095.

4. **Dr. Peter Fernandez. M.,**
   M.D., D.P.M., T.D.D., F.I.P.S.,
   Professor Emeritus (Psychiatry),
   DFHS,
   Porur- 600 125.

5. **Mrs. Jaslina Gnana Rani. J., M.Sc (N),**
   Reader, Dept of Medical Surgical Nursing,
   Apollo College of Nursing,
   Chennai – 600 095.

6. **Mrs. Anuradha. C., M. Sc (N),**
   Asst. Professor, Dept of Mental Health Nursing,
   Apollo College of Nursing,
   Chennai – 600 095.

7. **Mrs. Stella Mary. I., M.Sc (N),**
   Lecturer, Dept of Mental Health Nursing,
   Apollo College of Nursing,
   Chennai – 600 095.

APPENDIX - IX

RESEARCH PARTICIPANTS CONSENT FORM

Dear participant,

I am Jyothi. S. Sunandha., M.Sc., Nursing II Year Student of Apollo College of Nursing, Chennai. As a part of my curriculum requirement, a research on effectiveness of assertiveness training among the alcoholic patients in selected de-addiction centres at Chennai is selected to be conducted. The findings of the study will be helpful in identifying the level of assertiveness skills and self–esteem enhanced by the alcoholic patients.

I hereby seek your consent and cooperation to participate in the study. Please be frank and honest in your response. The information will be kept confidential and anonymity will be maintained.

Signature of the Researcher

I ……, here by consent to participate and undergo the study.

Signature of the Participant

ஆராய்ச்சியில் பங்கு பெறுபவருக்கான ஒப்புதல் படிவம்

அன்பார்ந்த பங்கு பெறுவோரே,

நான் அப்போலோ செவிலியர் கல்லூரியில் முதுகலை பயிற்ச்சி பெறும் மாணவி. என்னுடைய பயிற்ச்சியின் ஒரு பகுதியாக உறுதியாக்க பயிற்ச்சி பற்றி ஆராய்ச்சி செய்கிறேன். இந்த ஆராய்ச்சியில் நீங்கள் பங்கு பெற , உங்களுடைய ஒப்புதல் மற்றும் ஒத்துழைப்பையும் வேண்டுகிறேன். உங்களுடைய குறிப்புகள் இரகசியமாக வைக்கப்படும், மற்றும் உங்களுடைய பெயர் வேறு எங்கும் வெளியிடப்பட மாட்டாது.

ஆராய்ச்சியாளரின் கையொப்பம்

..... என்கிற நான், இந்த ஆராய்ச்சியில் பங்கு பெற ஒப்புதல் அளிக்கிறேன்.

பங்கு பெறுவோரின் கையொப்பம்

APPENDIX - X

CERITIFICATE FOR ASSERTIVENESS TRAINING

MIDAS SOFT SKILLS

Prasanthi, 252, 42nd Street, Sector 8, K.K. Nagar, Chennai - 6000 78.

Certificate

This is to certify that Mr/Mrs/Miss Jyothi S. Sunandha

has successfully completed the Course in

Assertiveness and Self esteem

Workshop/Class Conducted by us

from ..... to ..... given under the seal of Midas Soft Skills at Chennai.

Director

Chief Trainer

APPENDIX -XI

CERITIFICATE FOR ENGLISH EDITING

TO WHOMSOEVER IT MAY CONCERN

This is to certify that the dissertation, **"A Quasi Experimental Study to Assess the Effectiveness of Assertiveness Training upon Assertiveness Skills and Self-Esteem among Alcoholic Patients in Selected De-Addiction Centres, Chennai"** by Ms. **JYOTHI. S. SUNANDHA,** II year M.Sc (N) Student, Apollo College of Nursing, was edited for English Language appropriateness.

29/11/ Signature

A. SUUNDARARAJAN, M.A., B.Sc
P. G. Assistant in ENGLISH
rt N. Krishnasamy Mudaliar Hr. Sec.
Sainathapuram VELLORE - 632

APPENDIX - XII

CERITIFICATE FOR TAMIL EDITING

TO WHOMSOEVER IT MAY CONCERN

This is to certify that the dissertation, **"A Quasi Experimental Study to Assess the Effectiveness of Assertiveness Training upon Assertiveness Skills and Self-Esteem among Alcoholic Patients in Selected De-Addiction Centres, Chennai"** by **Ms. JYOTHI. S. SUNANDHA**, II year M.Sc (N) Student, Apollo College of Nursing, was edited for Tamil Language appropriateness.

Signature

Headmaster,
Govt. High School,
HOLICAL

APPENDIX – XIII

DEMOGRAPHIC VARIABLE PROFORMA OF ALCOHOLIC PATIENTS

Purpose: This Proforma is used to measure the demographic variables such as age, gender, educational status, occupation, marital status, monthly family income, number of children, religion, type of the family, family history of alcohol abuse etc.,

Instruction:

- ✓ Please put a tick mark (√) in the following options.
- ✓ Please be frank in answering.

Identification data:

Sample no: ☐

1. **Age in years:** ☐
2. **Educational status**
   - 2.1 Non literate ☐
   - 2.2 Primary education ☐
   - 2.3 Secondary education ☐
   - 2.4 Higher Secondary ☐
   - 2.5 Graduate & above. ☐
3. **Occupation**
   - 3.1 Unemployed ☐
   - 3.2 Student ☐
   - 3.3 Business ☐
   - 3.4 Labourers ☐
   - 3.6 Employed in some organisation ☐
   - 3.7 Retired ☐
   - 3.8 If others, Specify ☐

4. Marital status

4.1 Unmarried ☐

4.2 Married ☐

4.3 Separated ☐

4.4 Divorced. ☐

4.5 Widower ☐

5. Monthly family income .....

6. Number of children .....

7. Religion

7.1 Hindu ☐

7.2 Muslim ☐

7.3 Christian ☐

7.4 Others (specify) ☐

8. Type of the family

8.1 Nuclear ☐

8.2 Joint ☐

8.3 Extended ☐

9. Family history of alcohol abuse/ dependence

9.1 Yes ☐

9.2 No ☐

10. If yes, Specify the relationship .....

சமூக மற்றும் குடும்ப விவரங்களின் மாறுபட்டக் குறிப்புகளை அறியும் மாதிரிப்படிவம்

- ❋ தயவு கூர்ந்து பின்வருவனவற்றுள் தேர்ந்தெடுக்கக் கூடிய ஒன்றில் ✓ செய்யவும்.
- ❋ பதில் அளிப்பதில் வெளிப்படையாக இருக்கவும்.

<u>தன் நிலை விளக்கம்:</u>

<u>மாதிரி எண்</u> :

1. **வயது (ஆண்டுகளில்)** :
2. **கல்வித் தகுதி**
   - 2.1 படிக்கவில்லை ☐
   - 2.2 தொடக்கக் கல்வி ☐
   - 2.3 உயர் நிலைக் கல்வி ☐
   - 2.4 மேல் நிலைக் கல்வி ☐
   - 2.5 பட்டப்படிப்பு மற்றும் அதற்கும் மேல் ☐
3. **தொழில்**
   - 3.1 வேலையற்றவர் ☐
   - 3.2 மாணவர் ☐
   - 3.3 வியாபாரம் ☐
   - 3.4 உடல் உழைப்பாளி ☐
   - 3.5 ஏதேனும் ஒரு துறையில் வேலை செய்பவர் ☐
   - 3.6 ஓய்வு பெற்றவர் ☐
   - 3.7 மற்றவை எனில் குறிப்பிடவும் ☐
4. **திருமணத் தகுதி**
   - 4.1 திருமணம் ஆகாதவர் ☐
   - 4.2 திருமணம் ஆனவர் ☐
   - 4.3 பிரிந்திருப்பவர் ☐

4.4 விவாகரத்தானவர் ☐

4.5 மனைவியை இழந்தவர் ☐

5. குடும்பத்தின் மாத வருமானம் .....

6. குழந்தைகளின் எண்ணிக்கை .....

7. மதம்

7.1 இந்து ☐

7.2 இஸ்லாமியர் ☐

7.3 கிறித்துவர் ☐

7.4 மற்றவை எனில் (குறிப்பிடவும்) ☐

8. குடும்ப வகை

9.1 தனிக்குடும்பம் ☐

9.2 கூட்டுக் குடும்பம் ☐

9.3 விரிவு படுத்தப்பட்ட குடும்பம் ☐

9. குடும்பத்தில் எவரேனும் மதுவை பயன்படுத்துபவர் / மதுவுக்கு அடிமை

9.1 ஆம் ☐

9.2 இல்லை ☐

10. ஆம் எனில் உறவின் முறையைக் குறிப்பிடவும் .....

APPENDIX-XIV

CLINICAL VARIABLE PROFORMA OF ALCOHOLIC PATIENTS

Purpose:

This Proforma is used to assess the clinical variables such as age at which the alcohol consumption was started, Precipitating factor, Feelings when first consumed alcohol, Situations that provoked to consume more amount of alcohol, Duration, Frequency, Form, Amount, Money spent, History of usage of other addictive agents, associated symptoms, Associated complications, Problems arisen due to alcohol consumption, Efforts to quit or cut down alcohol in the past , History of abstinence, Reason for abstinence , Reason for restarting alcohol consumption, Previous history of Alcoholics De- Addiction Treatment, Belief in effectiveness of alcohol de-addiction treatment in dealing with addiction, History of psychiatric hospitalisation and the reason for hospitalization, motivation to seek treatment and source of information regarding treatment

Instructions:

- ✓ Please put a tick mark (√) in the following options.
- ✓ Please be frank in answering.

1. **Age at which the alcohol consumption was started** ……..
2. **Duration of alcohol dependence** ……....
3. **Precipitating factor for alcohol consumption**
   - 3.1 Peer pressure / Influence ☐
   - 3.2 Curiosity ☐
   - 3.3 Religious / Social acceptance ☐
   - 3.4 Family Problems ☐
   - 3.5 Financial Problems ☐
   - 3.6 Like the taste ☐
   - 3.7 For Enjoyment/ Pleasure ☐
   - 3.8 To forget or escape from problems ☐
   - 3.9 Seeing others using ☐

3.10 To manage feelings of anger, loss or other emotional pain ☐
3.11 Fatigue ☐
3.12 Excessive Worries ☐
3.13 Insomnia ☐
3.14 Academic Failure ☐
3.15 Difficulty in concentrating ☐
3.16 To be smart (Heroism) ☐
3.17 Lack of interest in day to day life ☐
3.18 To have self- confidence ☐
3.19 Overcome shyness ☐
3.20 Love Failure ☐
3.21 Pain / Other Physical Complaints ☐
3.22 Acculturation ☐
3.23 Poverty ☐
3.24 Unemployment ☐
3.25 Influence of cinema ☐
3.26 If others, Specify ☐

4. Feelings when you first consumed alcohol

4.1 Excited ☐
4.2 Relieved from all the problems ☐
4.3 Very relaxed ☐
4.4 Discomfort ☐
4.5 If others, Specify ☐

5. Situations that provoke you to consume more amount of alcohol

5.1 Peer pressure / Influence ☐
5.2 Work load ☐
5.3 Tension ☐
5.4 Anxiety ☐
5.5 Thinking about any problems ☐
5.6 Seeing others using ☐
5.7 Presence of other abusers ☐
5.8 Leisure time ☐

5.9 Development of tolerance (The dose is not adequate / Sufficient to produce the same effect as previous) ☐

5.10 Sight of alcohol ☐

5.11 Shooting Gallery/Alcohol taking restaurant ☐

5.12 Advertisements ☐

5.13 Pain/ Other Physical Problems ☐

5.14 Any special occasion ☐

5.15 If others, Specify ☐

6. Frequency of alcohol consumption

6.1 Everyday ☐

6.2 Several times a week ☐

6.3 Once a week ☐

6.4 Once a month ☐

6.5 Less than once a month ☐

7. Form of alcohol used

7.1 Country liquor ☐

7.2 Brandy ☐

7.3 Beer ☐

7.4 Wine ☐

7.5 Spirits (Gin, Vodka, Whisky etc) ☐

7.6 Rum ☐

7.7 If others, Specify ☐

8. Amount of alcohol consumed in a day (in ml) .....

9. Money spent on alcohol consumption per day .....

10. Source of money to buy alcohol

10.1 Family ☐

10.2 Friends ☐

10.3 Selling Belongings ☐

10.4 Stealing from family and friends ☐

10.5 Own earning ☐

10.6 If others, specify ☐

11. History of usage of other addictive agents

11.1 Tobacco smoking ☐

11.2 Cocaine ☐

11.3 Cannabis ☐

11.4 Heroin ☐

11.5 If others, Specify ☐

12. Any associated symptoms

12.1 Tremor in hands and fingers ☐

12.2 Feeling of choking ☐

12.3 Nervousness ☐

12.4 Sleep disturbances ☐

12.5 Eating less ☐

12.6 Memory disturbances ☐

12.7 Hearing voices/ Seeing things when alone ☐

12.8 If others, Specify ☐

13. History of associated complications

13.1 Heart diseases ☐

13.2 Diabetes ☐

13.3 Lung disease ☐

13.4 Peripheral neuropathy ☐

13.5 Liver disease ☐

13.6 Cancers ☐

13.7 Birth defects ☐

13.8 Depression ☐

13.9 If others, Specify ☐

14. Problems arisen due to alcohol consumption

14.1 Conflicts in relationship ☐

14.2 Trouble at work ☐

14.3 Legal trouble ☐

14.4 Disturbing reputation ☐

14.5 Financial difficulties ☐

14.6 If others, Specify ☐

15. Efforts to quit or cut down alcohol in the past

15.1 Yes ☐

15.2 No ☐

16. History of abstinence

16.1 Yes ☐

16.2 No ☐

17. If yes, reason for abstinence ……..

18. Reason for restarting alcohol consumption

18.1 Difficulty in concentration ☐

18.2 Loss of pleasure ☐

18.3 Craving ☐

18.4 To manage withdrawal symptoms ☐

18.5 Peer pressure / Influence ☐

18.6 Experimentation ☐

18.7 Controlled intake ☐

18.8 if others, specify ☐

19. Previous history of Alcoholics De- Addiction Treatment

19.1 Yes ☐

19.2 No ☐

20. Belief in effectiveness of alcohol de-addiction treatment in dealing with addiction

20.1 Yes ☐

20.2 No ☐

21. History of Psychiatric Hospitalisation

21.1 Yes ☐

21.2 No ☐

22. If Yes, the Reason for Psychiatric Hospitalization .....

23. Motivation to seek treatment

23.1 Wish to improve oneself ☐
23.2 Availability and awareness of treatment ☐
23.3 Family pressure ☐
23.4 Family responsibility ☐
23.5 Social disapproval ☐
23.6 Difficulty in getting substance ☐
23.7 Fear of physical illness ☐
23.8 Development of physical illness, Specify ☐
23.9 Fear of loss of job ☐
23.10 Due to religious values ☐
23.11 Observing recovered ones ☐
23.12 Fed up of using alcohol ☐
23.13Reasons for which alcohol was used was not fulfilled ☐
23.14 Financial difficulties (Inability to afford) ☐
23.15 Accidents ☐
23.16 If others, specify ☐

24. Source of information regarding treatment

24.1 General Practitioner ☐
24.2 Community health personnel including nurses ☐
24.3 Someone who had undergone treatment and has fully recovered now ☐
24.4 Family, Neighbours ☐
24.5 Friends ☐
24.6 Radio, Television, Newspaper ☐
24.7 Faith Healers ☐
24.8 If Others, Specify ☐

மருத்துவ விவரங்களின் மாறுபட்டக் குறிப்புகளை அறியும் மாதிரிப்படிவம்

- தயவு கூர்ந்து பின்வருவனவற்றுள் தேர்ந்தெடுப்பவைகளை ✓ செய்யவும்.
- பதில் அளிப்பதில் வெளிப்படையாக இருக்கவும்.

1. **எந்த வயதில் மது அருந்தும் பழக்கம் ஆரம்பமானது** .....
2. **மதுவுக்கு அடிமையான கால அளவு** .....
3. **மது அருந்தும் பழக்கத்திற்கு திடீரென/பலவந்தமாக ஈடுபட வைத்த காரணி**

3.1 ஒத்த வயதினரின் வற்புறுத்தல் / தாக்கம் ☐
3.2 ஆர்வம் ☐
3.3 மத / சமுதாய ஒப்புதல் ☐
3.4 குடும்பப் பிரச்சனைகள் ☐
3.5 பணப் பிரச்சனை ☐
3.6 சுவை பிடித்தது ☐
3.7 மகிழ்ச்சிக்காக ☐
3.8 துன்பங்களை மறப்பதற்கு / தப்பிப்பதற்கு ☐
3.9 மற்றவர்கள் பயன்படுத்துவதைப் பார்த்து ☐
3.10 கோபம், இழப்பு அல்லது மற்ற உணர்ச்சிகளின் வலி இவற்றைக் கட்டுப்படுத்த ☐
3.11 சோர்வு ☐
3.12 மிகுந்தத் துயரங்கள் ☐
3.13 தூக்கமின்மை ☐
3.14 படிப்பில் தோல்வி ☐
3.15 கவனம் செலுத்தலில் உள்ள கடினம் ☐
3.16 நாயகனைப்போல் தோன்ற ☐

3.17 தினசரி வாழ்க்கையில் ஈடுபாடு இல்லாமை

3.18 தன்னம்பிக்கைக் கொள்ள ☐

3.19 கூச்ச சுபாவத்திலிருந்து விடுபட ☐

3.20 காதலில் தோல்வி ☐

3.21 வலி / மற்ற உடல் பிரச்சனைகள் ☐

3.22 பிற கலாச்சாரத் தாக்கம் ☐

3.23 வறுமை ☐

3.24 வேலையின்மை ☐

3.25 சினிமாவைப் பார்த்து ☐

3.26 மற்றவை எனில் குறிப்பிடவும் ☐

4. முதன்முதலில் மது அருந்தியப்பொழுது உண்டான எண்ணங்கள்

4.1 மகிழ்ச்சியும் உற்சாகமும் அடைந்தேன் ☐

4.2 எல்லாத் துன்பங்களிலிருந்தும் விடுதலை ☐

4.3 மிகவும் ஓய்வாக உணர்ந்தேன் ☐

4.4 அசௌகர்யமாக உணர்ந்தேன் ☐

4.5 வேறு ஏதேனுமெனில் குறிப்பிடவும் ☐

5. அதிக மது அருந்த தூண்டும் தருணங்கள்

5.1 ஒத்த வயதினரின் வற்புறுத்தல் / தாக்கம் ☐

5.2 வேலைப் பளு ☐

5.3 பதற்றம் ☐

5.4 மனப் பதட்டம் ☐

5.5 ஏதேனும் பிரச்சனைகள் பற்றி சிந்தித்தல் ☐

5.6 மற்றவர்கள் பயன்படுத்துவதை பார்க்கும்பொழுது ☐

5.7 மற்ற முறைக்கேடாகப் பயன்படுத்துபவர்கள் இருக்கும்பொழுது ☐

5.8 ஓய்வு நேரம் ☐

5.9 அதிக போதையை ஏற்படுத்த (முன்பு அருந்திய ☐

மது போதுமானப் போதையைத் தராததால்)

5.10 மதுவைப் பார்க்கும்பொழுது ☐

5.11 படப்பிடிப்பு தளம் / மது அருந்தும் விடுதி ☐

5.12 விளம்பரங்கள் ☐

5.13 வலி / மற்ற உடல் உபாதைகள் ☐

5.14 முக்கிய நிகழ்வுகளில் ☐

5.15 வேறு ஏதேனும் எனில் குறிப்பிடவும் ☐

6. அடிக்கடி மது அருந்தும் கால அளவு

6.1 தினசரி ☐

6.2 ஒரு வாரத்தில் பல முறை ☐

6.3 வாரத்திற்கு ஒரு முறை ☐

6.4 மாதத்திற்கு ஒரு முறை ☐

6.5 ஒரு மாதத்திற்கும் குறைவாக ☐

7. பயன்படுத்தும் மது வகை

7.1 நாட்டு மது ☐

7.2 பிராந்தி ☐

7.3 பீர் ☐

7.4 ஒயின் ☐

7.5 எரிச் சாராயம் (ஜின், வோட்கா, விஸ்கி, மற்றவை) ☐

7.6 ரம் ☐

7.7 வேறு ஏதேனும் எனில் குறிப்பிடவும். ☐

8. ஒரு நாளில் அருந்தும் மதுவின் அளவு (மில்லி அளவில் குறிப்பிடவும்)

9. ஒரு நாளைக்கு அருந்தும் மதுவிற்கு செலவிடப்படும் பணம் .....

10. மது வாங்க பணம் பெறும் வழி

10.1 குடும்பத்திலிருந்து ☐

10.2 நண்பர்கள் மூலம் ☐

☐

10.3 உடமைகளை விற்பதன் மூலம்

10.4 திருடுதல் ☐

10.5 சொந்த சம்பாத்தியம் ☐

10.6 வேறு ஏதேனும் எனில் குறிப்பிடவும் ☐

11. அடிமையாகிவிட்ட மற்றப் பொருட்களின் வரலாறு

11.1 புகைப் பழக்கம் ☐

11.2 கொக்கெய்ன் (வெறி மயக்கப் பொருள்) ☐

11.3 கன்னபிஸ் (புகைக்கப்படும் வெறி மயக்கப் பொருள்) ☐

11.4 ஹெராயின் (போதைப் பொருள்) ☐

11.5 வேறு ஏதேனும் எனில் குறிப்பிடவும் ☐

12. ஏதேனும் தொடர்புடைய உடல் அறிகுறிகள்

12.1 கைகளில் மற்றும் விரல்களில் நடுக்கம் ☐

12.2 மூச்சுத் திணறல் உணர்வு ☐

12.3 நரம்புத்தளர்ச்சி ☐

12.4 தூங்குவதில் இடையூறுகள் ☐

12.5 குறைவாக சாப்பிடுதல் ☐

12.6 நினைவாற்றல் இடையூறுகள் ☐

12.7 குரல்கள் கேட்பது / தனிமையில் பொருட்களைப் பார்ப்பது ☐

12.8 வேறு ஏதேனும் எனில் குறிப்பிடவும் ☐

13 தொடர்புடைய உடல் கோளாறுகளின் வரலாறு

13.1 இருதய நோய்கள் ☐

13.2 நீரிழிவு நோய் ☐

13.3 நுரையீரல் நோய் ☐

13.4 தசைத் தளர்ச்சி நோய் ☐

13.5 குடல் நோய் ☐

13.6 ஈரல் நோய் ☐

13.7 பிறவி குறைப்பாடுகள் ☐

13.8 மன அழுத்தம் ☐

13.9 வேறு ஏதேனும் எனில் குறிப்பிடவும் ☐

14 மது அருந்துவதால் உண்டானப் பிரச்சனைகள்

14.1 உறவுகளில் கருத்து வேறுபாடு ☐

14.2 வேலை செய்யும் இடத்தில் பிரச்சனை ☐

14.3 சட்டப் பிரச்சனை ☐

14.4 கொளரவப் பிரச்சனை ☐

14.5 பணப் பிரச்சனை ☐

14.6 வேறு ஏதேனும் எனில் குறிப்பிடவும் ☐

15 மது அருந்துவதை விட்டுவிடவோ அல்லது குறைக்கவோ முயற்சி எடுத்ததுண்டா?

14.1 ஆம் ☐

14.2 இல்லை ☐

16 மதுப் பழக்கத்தை விட்டு சில நாட்களாவது குடிக்காமல் இருந்ததுண்டா?

16.1 ஆம் ☐

16.2 இல்லை ☐

17 ஆம் எனில், விலகக் காரணம் .....

18 மீண்டும் மதுப் பழக்கத்துக்கு ஆளாகக் காரணம்

18.1 கவனம் செலுத்துவதில் சிரமம் ☐

18.2 மகிழ்ச்சி இழப்பு ☐

18.3 வேட்கை ☐

18.4 இழப்பின் அறிகுறிகளைச் சரிச் செய்ய ☐

18.5 ஒத்த வயதினரின் வற்புறுத்தல் / தாக்கம் ☐

18.6 ஆராய்ச்சிச் செய்துப் பார்த்தல் ☐

18.7 கட்டுப்பாடுடன் உட்கொள்ளுதல் ☐

18.8 வேறு ஏதேனும் எனில் குறிப்பிடவும் ☐

19 மதுப்பழக்கத்திலிருந்து விடுபட மருத்தவ முயற்சி எடுத்ததுண்டா?

19.1 ஆம் ☐

19.2 இல்லை ☐

20 மதுப்பழக்கத்திலிருந்து விடுபட மருத்தவ முயற்சி எடுப்பதில் நம்பிக்கை உண்டா?

20.1 ஆம் ☐

20.2 இல்லை ☐

21 மனநோய்க்காக மருத்தவமனை சென்றதுண்டா?

21.1 ஆம் ☐

21.2 இல்லை ☐

22 **ஆம், எனில் மருத்துவமனைக்குச் செல்லக் காரணம்?** .....

23 குணப்படுத்திக் கொள்ளக் கிடைக்கும் ஊக்கம் எவை?

23.1 தன்னிலை உயர்த்திக் கொள்ள ☐

23.2 மருத்துவம் பற்றிய விழிப்புணர்வும், வாய்ப்பும் ☐

23.3 குடும்ப நச்சரிப்பு ☐

23.4 குடும்பப் பொறுப்பு ☐

23.5 சமுதாயம் ஏற்றுக்கொள்ளாமை ☐

23.6 மதுக் கிடைப்பதில் சிரமம் ☐

23.7 உடல்நிலைச் சரியில்லாமல் போய்விடும் என்ற பயம் ☐

23.8 உடல்நிலைக் கெடுதல், குறிப்பிடவும் .....

23.9 வேலைப் போய்விடும் என்ற பயம் ☐

23.10 மதம் போதிக்கும் மதிப்புகளால் ☐

23.11 மதுப்பழக்கத்திலிந்து மீண்டவர்களைப் பார்க்கும்பொழுது ☐

23.12 மது மீது ஏற்ப்பட்ட சலிப்பு ☐

23.13 மது அருந்தக் காரணங்கள் நிறைவேறாமை ☐

23.14 பணக்கஷ்டம் (நிலையான வருமானமின்மை) ☐

23.15 விபத்துக்கள் ☐

23.16 வேறு ஏதேனும் எனில் குறிப்பிடவும் ☐

24 மருத்துவம் பெறத் தகவல் கிடைக்கும் வழி

24.1 பொது மருத்துவர் ☐

24.2 சமூக நல மருத்துவர்கள் மற்றும் செவிலியர்கள் ☐

24.3 மருத்துவம் எடுத்துக் கொண்டதால் குணம் அடைந்தவர் மூலம் ☐

24.4 குடும்பம், அண்டை அயலார் மூலம் ☐

24.5 நண்பர்கள் ☐

24.6 வானொலி, தொலைக்காட்சி, செய்தித்தாள் ☐

24.7 இறை நம்பிக்கை மூலம் குணப்படுத்துபவர் ☐

24.8 வேறு ஏதேனும் எனில் குறிப்பிடவும் ☐

BLUE PRINT FOR RATHUS ASSERTIVENESS SCHEDULE

S.No	Content	Items	Total	Percentage (%)

1.	Questions about apprehension related to interpersonal communication	2,10,11,15, 22,26	6	20
2.	Questions related to self concept	1,4,6,7,8, 9,17,21,23, 24,28,29,30	13	43.3
3.	Questions about apprehension related to public speaking	3,5,12,13, 14,16,18,19, 20,25,27	11	36.7
		Total	**30**	**100%**

APPENDIX - XV

RATHUS ASSERTIVENESS SCHEDULE

It is a standardised tool developed by Spencer Rathus.A. (1978).

Purpose: This tool consists of 30 items to measure the assertiveness skill. The scale is a 6 point likert scale. The score ranges from -3 to +3. (Very much like me, Rather like me, Slightly like me, Slightly unlike me, Rather unlike me, Very much unlike me)

Thus the total obtainable score range will be -90 to +90.

Instruction: Kindly read the statements. Indicate how well each statement describes you by placing a (√) mark. Describe your responses honestly without any restraints. The responses will be kept confidential and used for research purpose only.

S.No	Items	Very much like me	Rather like me	Slightly like me	Slightly unlike me	Rather unlike me	Very much unlike me
1.	Most people seem to be more aggressive and assertive than I am.						
2.	I have hesitated to make or accept invitations for social gatherings because of "Shyness."						
3.	When the food served at a restaurant is not done to my satisfaction, I complain about it to the waitress or waiter.						
4.	I am careful to avoid hurting other people's feelings even when I feel that I have been						

5.	injured.						
6.	If a salesman has gone to considerable trouble to show me merchandise which is not quite suitable, I have a difficult time saying "No."						
7.	When I am asked to do something, I insist upon knowing why.						
8.	There are times when I look for a good, vigorous argument. I strive to get ahead as well as most people in my position.						
9.	To be honest, people often take advantage of me. I enjoy starting conversations with new acquaintances and strangers.						
10.	I often don't know what to say to people I find attractive.						
11.	I will hesitate to make phone calls to business establishments and institutions.						
12.	I would rather apply for a job or for admission to a college by writing letters than by going						
13.	through with personal interviews						
14.	I find it embarrassing to return merchandise						

15.	If a close and respected relative were annoying me, I would smother my feelings rather than express my annoyance.						
16.	I avoid asking questions for fear of sounding stupid.						
17.	During an argument I am sometimes afraid that I will get so upset that I will shake all over.						
18.	If a famed and respected lecturer makes a statement I think is incorrect, I will have the audience hear my point of view as well.						
19.	I avoid arguing over prices with clerks and salesmen.						
20.	When I have done something important or worthwhile, I manage to let others know about it.						
21.	I am open and frank about my feelings.						
22.	If someone has been spreading false and bad stories about me, I see him/her as soon as possible to have a "talk" about it.						
23.	I often have a hard time saying, "No."						
24.	I tend to bottle up my emotions rather than make a scene.						

25.	I complain about poor service in a restaurant and elsewhere.						
26.	When I am given a complement, I know how to handle it and what to say.						
27.	If a couple near me in a theatre or at a lecture were conversing rather loudly, I would ask them to be quiet or to take their conversation elsewhere.						
28.	Anyone attempting to push ahead of me in a line is in for a good battle.						
29.	I am quick to express an opinion.						
30.	There aren't many times when I don't know what to say.						

Scoring key:

Scores are calculated as follows:

- For items 3, 4, 5,6,7,8,10,18,20,21,22,25,27,28 and 29:

  Very much like me =3

  Rather like me =2

  Slightly like me =1

  Slightly unlike me =-1

  Rather unlike me =-2

  Very much unlike me =-3

- For items 1,2,4,5,9,11,12,13,14,15,16,17,19,23,24,26 and 30 (which are reversed in valence):

  Very much like me =-3

  Rather like me =-2

  Slightly like me =-1

  Slightly unlike me =1

  Rather unlike me =2

  Very much unlike me =3

Sum the scores for the 30 items.

Score interpretation

S.No	Score	Interpretation
1.	-90 to +20	Non-Assertive
2.	+20 to 90	Assertive

ரத்தூஸ் உறுதியானக் கருத்தைக் கூறும் திட்டம்

அறிவுறை: தயவுக்கூர்ந்து வாக்கியங்களைப் படிக்கவும். அவை எந்த அளவுக்கு உங்களைக் குறிப்பிடுகிறது என்பதை ✓ செய்யவும். எந்தவிதக் கட்டுப்பாடுமின்றி உங்கள் பதில்களை உண்மையாக குறிப்பிடவும். உங்கள் பதில்கள் ரகசியாகமாக வைக்கப்பட்டு ஆராய்ச்சிக்காக மட்டுமேப் பயன்ப்படுத்தப்படும்.

வ.எண்	வகைகள்	மிகவும் என்னைப்போல்	என்னைப்போல்	கொஞ்சம் என்னைப்போல்	கொஞ்சம் என்னைப்போல் அல்லாமல்	என்னைப்போல் அல்லாமல்	மிகவும் என்னைப்போல் அல்லாமல்
1.	பலப்பேர் என்னைவிட மூர்க்கமாகவும் உறுதியாகவும் உள்ளனர்.						
2.	வெட்கம் காரணமாக சமூக விழாக்களுக்கு செல்வதையோ, அழைப்பை ஏற்கவோ தயங்கியுள்ளேன்.						
3.	உணவு விடுதியில் பறிமாறப்படும் உணவு சரியில்லை எனில் பறிமாறுபவரிடம் புகார் அளிப்பேன்.						
4.	நான் காயப்பட்டதாக உணர்ந்தாலும் அடுத்தவர் மனதைக் காயப்படுத்துவதைத் தவிர்ப்பதில் கவனமாக உள்ளேன்.						
5.	விற்பனையாளர் சிரமப்பட்டு எனக்குப் பொருந்தாத ஒன்றைக் காட்டும்பொழுது வேண்டாம் என சொல்ல தயங்குகிறேன்.						
6.	ஏதேனும் என்னைச் செய்யச் சொன்னால் ஏன் எனத்						

	தெரிந்துக் கொள்ள விரும்புகிறேன்.						
7.	நல்ல தீர்க்கமான விவாதத் தருணத்தை நான் எதிர்ப்பார்க்கிறேன்.						
8.	நான் மற்றவர்களைவிட உயர வேண்டும் என முயற்சிக்கிறேன்.						
9.	உண்மையில், பலர் என்னைப் பயன்படுத்திக் கொள்கிறார்கள்.						
10.	புதிய நண்பர்களுடன், புதியவர்களுடன் பேசுவதில் மகிழ்கிறேன்.						
11.	கவர்ச்சியானவர்களைப் பார்க்கும்பொழுது பலநேரங்களில் என்ன சொல்வது என்றுத் தெரியவில்லை.						
12.	வியாபாரத் தளங்கள் மற்றும் கல்வி நிறுவனங்களுக்குத் தொலைப்பேசியில் பேசத் தயங்குகிறேன்						
13.	வேலைக்கோ அல்லது கல்லூரியில் சேர்வதற்கோ நேர்க்காணலைவிட கடிதங்கள் எழுதுவதையே விரும்புகிறேன்.						
14.	வாங்கிய பொருட்களைத் திரும்பக் கொடுக்க சங்கடப்படுகிறேன்.						
15.	நெருங்கிய மற்றும் மரியாதைக்குரிய உறவினர்கள் என்னை புண்படுத்தும்பொழுது கோபம் கொள்ளாமல் மனதைக் கட்டுப்படுத்துவேன்.						
16.	முட்டாள்தனமாக இருக்குமோ என்று						

	கேள்விகள் கேட்பதைத் தவிர்க்கிறேன்.						
17.	வாக்குவாதத்தின்பொழுது சில நேரங்களில் நான் மிகவும் மனம் உடைந்து, உடல் நடுங்குமோ எனப் பயப்படுகிறேன்.						
18.	புகழ்ப்பெற்ற மரியாதைக்குரிய விரிவுரையாளர் ஒருக் கருத்தைச் சொல்லும்பொழுது, அது தவறாக இருந்தால் என் கருத்தை நான் அவையில் கூறுவேன்.						
19.	எழுத்தர்கள் மற்றும் விற்பனைச் செய்யும் ஊழியர்கள் இவர்களுடன் விலைகளைப் பற்றி வாதம் செய்வதைத் தவிர்க்கிறேன்.						
20.	நான் முக்கியமான உருப்படியான ஒன்றைச் செய்யும்பொழுது அதனை மற்றவர் அரிய முயற்சி செய்கிறேன்.						
21.	என்னுடைய உணர்வுகளை வெளிப்படையாக வைத்துள்ளேன்.						
22.	எவரேனும் என்னைப் பற்றிப் பொய்யான மற்றும் தவறானக் கதைக் கட்டினால் உடனடியாக அவர்களிடம் பேசுவேன்.						
23.	“இல்லை” என்று சொல்ல சங்கடப்படுகிறேன்.						
24.	என்னுடைய ஆழ்ந்த உணர்வுகளை						

	வெளிப்படுத்தாமல் கட்டுப்படுத்துகிறேன்.						
25.	உணவு விடுதி மற்றும் மற்ற இடங்களில் சேவைச் சரி இல்லை எனில் புகார் செய்வேன்.						
26.	என்னைப் பாராட்டினால் அதனை எப்படிக் கையாள்வது, என்ன சொல்வது என்று எனக்குத் தெரியும்.						
27.	திரையரங்கிலோ, வகுப்பிலோ இருவர் சத்தமாகப் பேசினால் அவர்களை அமைதியாக இருக்கும்படி அல்லது வேறு இடம் சென்றுப் பேசுமாறு சொல்வேன்.						
28.	வரிசையில் நிற்கும்பொழுது என்னைத் தள்ளினால் சண்டைப் போடுவேன்.						
29.	கருத்தைச் சொல்வதில் வேகமாக இருப்பேன்.						
30.	என்ன சொல்வது என்றுத் தெரியாமல் நான் பல நேரங்களில் விழித்ததில்லை.						

APPENDIX - XVI

ROSENBERG SELF ESTEEM SCALE

It is a standardised tool to measure Self- Esteem developed by Dr.Morris Rosenberg.

Purpose: This tool consists of 10 items to measure the Self-Esteem. The scale is a 4 point likert scale. The scores range from 0 to 3. (Strongly Agree, Agree, Disagree, Strongly Disagree)

Thus the total obtainable score range will be 0 to 30.

Higher the score, higher the level of self-esteem.

Instruction: Below is a list of statements dealing with your general feelings about yourself. Kindly read the statements. Indicate how well each statement describes you by placing a (√) mark. Describe your responses honestly without any restraints. The responses will be kept confidential and used for research purpose only.

S. No	Items	Strongly Agree	Agree	Disagree	Strongly Disagree
1.	On the whole I am satisfied with myself.				
2.	At times, I think I am no good at all.				
3.	I feel that I have a number of good qualities.				
4.	I am able to do things as well as most other people.				
5.	I feel I do not have much to be proud of.				
6.	I certainly feel useless at times.				
7.	I feel that I'm a person of worth at least on an equal plane with others.				
8.	I wish I could have more respect for myself.				
9.	All in all I am inclined to feel that I am a failure.				
10.	I take a positive attitude towards myself				

Scoring key:

Scores are calculated as follows:

- For items 1, 3, 4, 7, and 10:

Strongly agree	=	3
Agree	=	2
Disagree	=	1
Strongly disagree	=	0

- For items 2, 5, 6, 8 and 9 (which are reversed in valence):

Strongly agree	=	0
Agree	=	1
Disagree	=	2
Strongly disagree	=	3

Sum the scores for the ten items.

Score interpretation:

S.No	Score	Interpretation
1.	<15	Low self-esteem
2.	15-25	Normal
3.	>25	High self-esteem

ரோசென்பெர்கின் உயர்மதிப்பு அளவுகோல்

அறிவுரைகள்:

கீழே உங்களைப்பற்றி உங்களுடையப் பொதுவான உணர்வுகளைக் கொண்ட வாக்கியப் பட்டியல் உள்ளது. தயவு கூர்ந்து அவற்றைப் படிக்கவும். அவை எந்த அளவுக்கு உங்களைப் பற்றி விளக்குகிறது என்பதை ✓ செய்யவும். எந்தத் தயக்கமும் இன்றி உங்கள் பதில்களை உண்மையாக அளிக்கவும். உங்கள் பதில்கள் இரகசியமாக வைக்கப்படும் மற்றும் ஆய்வுக்காக மட்டுமேப் பயன்ப்படுத்தப்படும்.

வ. எண்	வகைகள்	உறுதியாக ஒத்து கொள்கிறேன்	ஒத்து கொள்கிறேன்	மறுக்கிறேன்	உறுதியாக ஏற்க மறுக்கிறேன்
1.	மொத்தத்தில் என்மீது எனக்குத் திருப்தி உள்ளது.				
2.	சில நேரங்களில் நான் சரியில்லை என நினைக்கிறேன்.				
3.	என்னிடம் பல நல்ல குணங்கள் இருப்பதாக உணர்கிறேன்.				
4.	பலரைப்போல் என்னாலும் பலக் காரியங்களைச் செய்ய இயலும்.				
5.	என்னிடம் பெருமைப் பட அதிகம் ஒன்றும் இல்லை என்று நான் உணர்கிறேன்.				
6.	சில நேரங்களில் நான் ஒரு உதவாக்கரை என்றுக் கண்டிப்பாக உணர்கிறேன்.				
7.	குறைந்தது அடுத்தவர்களுக்குச் சமமாக மதிப்பு உள்ளவன் என உணர்கிறேன்.				
8.	எனக்கு இன்னும் நிறைய மரியாதை வேண்டும் என்று விரும்புகிறேன்.				
9.	மொத்தத்தில் நான் தோற்றுவிட்டதாக உணர வைக்கப்படுகிறேன்.				
10.	ஆக்கப்பூர்வமான மனோபாவத்தை நான் கொண்டுள்ளேன்.				

BLUE PRINT FOR LEVEL OF SATISFACTION

S.No	Content	Items	Total	Percentage (%)
1.	Questions related to the researcher	1,2,3	3	30
2.	Questions related to assertiveness training	4,5,6,7,8,9,10	7	70
		Total	**10**	**100%**

APPENDIX – XVII

RATING SCALE ON THE LEVEL OF SATISFACTION UPON

ASSERTIVENESS TRAINING AMONG ALCOHOLIC PATIENTS

This tool is developed by the investigator.

Purpose:

This rating scale is designed to assess the level of satisfaction of the participants.

Instruction:

There are 10 items below. Kindly read the items. Response extends from highly satisfactory, satisfactory to highly dissatisfactory. Put a tick mark against your answers. Describe your responses freely and frankly. The responses will be kept confidential and used for research purpose only.

S.No	Items	Highly Satisfied	Satisfied	Dissatisfied	Highly Dissatisfied
1.	Explanation regarding assertiveness training				
2.	Approach of the researcher				
3.	Time spend by the researcher				
4.	Duration of the programme				
5.	Arrangements made during the programme				
6.	The programme was easy to understand				
7.	Use of audio visual aids				
8.	Involvement of the participants				
9.	Given at the appropriate time				
10.	Usefulness				

Scoring key

Highly dissatisfied	- 1
Dissatisfied	-2
Satisfied	-3
Highly satisfied	-4

The total score is converted into percentage and graded as given below.

Score interpretation

S.No	Scoring	Interpretation
1.	Highly Satisfied	76-100%
2.	Satisfied	50-75%
3	Dissatisfied	25-50%
4.	Highly dissatisfied	≤25%

பங்குப்பொற்றோரின் திருப்திக்கான நிலையை அறியும் அளவுகோல்

அறிவுரை:

பத்து வகைகள் கீழே உள்ளன. பதில்கள் மிகவும் திருப்தி, திருப்தியிலிருந்து மிகவும் அதிருப்தி வரை விரிந்துள்ளது. உங்கள் பதில்களுக்கு நேராக ✓ செய்யவும். உங்கள் பதில்களை சுதந்திரமாகவும் வெளிப்படையாகவும் கூறவும். உங்கள் பதில்கள் இரகசியமாக வைக்கப்படும் மற்றும் ஆய்வுக்காக மட்டுமேப் பயன்ப்படுத்தப்படும்.

வ.எண்	வகைகள்	மிகவும் திருப்தி	திருப்தி	திருப்தியில்லை	மிகவும் திருப்தியில்லை
1.	உறுதியாக்கப் பயிற்சிப் பற்றிய விளக்கம்				
2.	ஆய்வாளரின் அணுகு முறை				
3.	ஆய்வாளர் செலவழித்த நேரம்				
4.	நிகழ்ச்சியின் கால அளவு				
5.	நிகழ்ச்சியின் பொழுது செய்யப்ப ஏற்ப்பாடுகள்				
6.	நிகழ்ச்சிப் புரிந்துக் கொள்ள எளித இருந்தது				
7.	ஒலி ஒளி உபகரணங்களின் பயன்பாடு				
8.	பங்குபொற்றோரின் ஈடுபாடு				
9	சரியான நேரத்தில் கொடுக்கப்பட்டது				
10.	பயன்பாடு				

APPENDIX - XVIII

Item Wise Frequency and Percentage Distribution of Level of Satisfaction Scores of Assertiveness Training in the Experimental Group of Alcoholic Patients

Item	Experimental group (n=30)							
	Highly satisfied		Satisfied		Dissatisfied		Highly dissatisfied	
	n	p	n	p	n	p	n	p
Explanation regarding assertiveness training	18	60	12	40	-	-	-	-
Approach of the researcher	16	53.33	14	46.67	-	-	-	-
Time spend by the researcher	12	40	18	60	-	-	-	-
Duration of the programme	13	43.33	17	56.67	-	-	-	-
Arrangements made during the programme	17	56.67	13	43.33	-	-	-	-
The programme was easy to understand	25	83.33	5	16.67	-	-	-	-
Use of audio visual aids	17	56.67	13	43.33	-	-	-	-
Involvement of the Participants	26	86.67	4	13.33	-	-	-	-
Given at the appropriate time	21	70	7	30	-	-	-	-
Usefulness	28	93.33	2	0.07	-	-	-	-

It can be inferred from the table that majority of them (93.33%) were highly satisfied with all the aspects of assertiveness training.

APPENDIX - XIX

ASSERTIVENESS TRAINING SCHEDULE

Days	Method /Activity	Content	Time
1	Discussion	**Introduction**	15 mins
	Power point presentation , Role Plays , Work Sheets	**Assertiveness- the right strategy** ➢ Meaning of assertiveness ➢ Benefits of being assertive ➢ The basic assertive rights ➢ The passive , assertive and aggressive pattern of communication	45 mins
2.	Demonstration , Hand outs, Videoshows	**Prepare to assert yourself** ➢ Tension control ➢ Inner calm	30 mins
3.	Power point presentation , Video shows	**Developing confidence through assertiveness** ➢ Self-awareness and self-esteem ➢ Positive self-image ➢ Positive language ➢ Positive affirmations ➢ Positive outcomes	1 hour
4.	Lecture, Exercises Work sheets	**Words and phrases** ➢ Changing others by changing yourself ➢ Direct, assertive communication ➢ Honesty ➢ Spontaneity	30 mins
	Role plays , work sheets	**Now and then** ➢ How assertive are you? ➢ The sweeter way of saying “No”	30 mins
5.	Role plays , Video shows	**Power** ➢ Confident delivery ➢ Volume ➢ Intonation ➢ Projection ➢ Position and status	30 mins

	Role Plays, Video shows , Exercises	**Body talk** ➢ Body language	30 mins
6.	Role plays	**Now see hear** ➢ Listening ➢ Conflict resolution	1 hour
7.	Discussion, Worksheets, Exercises	**Relationships** ➢ Matching ➢ Mirroring ➢ Relationships with relatives	30 mins
	Role plays	**Problem people** ➢ The irate ➢ The stayer ➢ The rabbit ➢ Your boss ➢ The critic	30 mins
8.	Discussion, Role plays, Work- sheets, Videoshows	**Tricky situations** ➢ Giving criticism ➢ Compliments	30 mins
9.	Lecture , Discussion, Role plays	**Assertiveness and alcoholism**	1 hour
10.	Lecture , Discussion, Role plays	**Drinking refusal skill training**	1 hour

APPENDIX - XX

LESSON PLAN ON ASSERTIVENESS TRAINING

CONTENT FOR TEACHING

TOPIC -Assertiveness Training.

Group -Alcoholic patients.

Place -Wisdom Hospitals, Saidapet, Chennai.

Duration -10 day's program.

Method of teaching -Lecture cum discussion, Role plays, Innovative methods, Interactive exercises.

Teaching aids -Power Point Presentations, Hand Outs and Black Board.

Educator -II year M.Sc., (N) Student, Apollo College of Nursing, Chennai.

General objective

The alcoholic patients will gain adequate knowledge on assertiveness, develop desirable attitude towards building the competencies of assertiveness and to achieve this personal mastery.

Specific objective

By the end of the program, the alcoholic patients will be able to,

- explain assertiveness as the right strategy.
- prepare themselves for assertion.
- demonstrate confidence through assertiveness
- choose the right words and phrases to communicate.
- practice the art of sweeter way of saying 'No'.

- deliver the message with power.
- display effective body language to communicate.
- specify the importance of assertive listening.
- demonstrate confidence through assertiveness.
- utilize assertive strategies in relationships.
- apply assertive strategies in tricky situations.
- execute assertive strategies in dealing with problem people.
- demonstrate assertiveness in quiting alcoholism.
- resist pressure to drink alcohol.

Time	Specific Objectives	Content	Teachers and Learners activity	A.V. aids	Evaluation
15 mins	The alcoholic patients will be able to,	**Introduction** Assertiveness is the ability to express oneself with confidence without having to resort to passive, aggressive or manipulative behaviour. It involves greater self-awareness, like and be in charge of the real 'you'. It requires listening and responding to the needs of others without neglecting your own interests or compromising your principles. This does not just mean choosing the right words to say in a given situation. Tone of voice, intonation, volume, facial expression, gesture and body language all play a part.	Introducing the topic and participating in discussion	PPT	What is the topic we are going to discuss today?
45 mins	explain assertiveness as the right strategy	**Assertiveness- the right strategy** **What is assertiveness?**  Assertiveness is a way of thinking and behaving that allows a person to stand up for his or her rights while respecting the rights of others. It is the ability to communicate your needs, feelings, opinions, and beliefs in an open and honest manner without violating the rights of others.	Lecture, Discussion, Role plays, listening and participating in discussion	PPT, Work sheets, Role plays	Why do you think assertiveness as the right strategy?

		Why Assertiveness Is Important? ➢ Helps you become self-confident ➢ Increases self-esteem ➢ Gain respect of others ➢ Improve communication skills ➢ Improve decision-making ability  ➢ Brings about the achievement of individual and/or shared goals. ➢ Increases your ability to reach these goals while maintaining your rights and dignity. **What's keeping you from being Assertive?** ➢ Fear of change ➢ Refusal to admit their submissiveness ➢ Fear of ruining relationships if you speak your mind ➢ Fear of rejection ➢ Lack of confidence in your ability **Rights and wrongs** An assertive system of 'rights' has to incorporate mutual respect for each other's needs, opinions and feelings. The important point to remember is that for every right you have, the other person has similar rights. For example, you have the right to ask for what you want. The other person has an equal right to refuse your request, or indeed to			

		request something of you. If you ignore another's rights, this is aggressive behaviour. If you ignore your own rights, you are being passive. ***"You have the right to be the final authority for what you are, and what you do."*** Irrespective of the roles you have in life, this right applies in every area of your life: business, social and personal. **Prepare to assert yourself** **Tension control**			
30 mins	prepare themselves for assertion	If anxiety produces observable signs of apprehension, this will convey itself to the other person and communication will suffer as a result. There are a number of coping strategies like a stiff drink before an important encounter, meditative trance, or deep-breathing exercises. **Inner calm** Allow a few minutes each day to relax body by methods like listening to calming music, meditating, soaking in a hot bath. When the body is at ease, imagine yourself in a place of beauty and calm, like lying in the hot sun on a golden beach listening to the waves, or enjoying a woodland walk full of spring flowers and birdsong. Employ your imagination and concentrate on the sensations experienced. What sounds can you hear? What can you see? How do you feel? You are now	Lecture, Demonstration, Listening and Return Demonstration	Video Shows, Handouts	How would you prepare yourself to be assertive?

		exercising your mind in a positive way, emptying it of unhelpful distractions, learning to achieve an inner calm and so increasing your ability to function assertively, whatever life deals you. **Developing confidence through assertiveness** **Self-awareness and self-esteem**			
1 hour	demonstrate confidence through assertiveness	Habitually functioning in a passive or aggressive way, can be bad for health, and certainly won't win friends or enable you to influence people. A common factor to both aggressive and passive behaviour is low self-esteem. A way to enhance your self-esteem is to know yourself **Positive thinking** Assertive people have a positive self-image, use positive language, look for positive outcomes to interactions, work with the other person to provide positive solutions to problems by which both sides 'win'. **Positive self-image** The image you present to others, whether by physical appearance, the clothes, hairstyle, body language you use, has a lot to do with whether others perceive you as assertive. e.g., Things like wearing the wrong clothes at a party which knocks confidence. **Positive language** Phrase things in a positive rather than negative way. For instance, there is a subtle difference between saying to a child 'Don't play with	Lecture and listening	PPT, Video Shows, Role plays, interactive exercises	How to develop confidence by being assertive?

that in here' and 'Would you play with that outside, please'. Positive phrasing helps to keep conversation on an adult –adult basis.

Positive assertions

Statements like 'I'll be hopeless' can easily become self-fulfilling prophecy. Such thoughts should be replaced by positive assertions. Look every problem, as an opportunity. Don't hope it will be OK; know that you will manage it well.

Positive affirmations

Most of us indulge in a lot of negative inner dialogue like,

- 'I am a failure'
- 'I can't cope.'
- 'Perhaps I just don't have what it takes.'

Miserable thoughts drain energy and power. Recognise this negative internal chattering and replace it with positive self-talk.

Positive outcomes

If an interpersonal conflict threatens, do you avoid confrontation? Do you adopt an 'anything for a quiet life' attitude? Do you set out 'win' at any price? Do you look for a compromise? All you need to try to achieve a win–win solution?

30 mins	choose the right words and phrases to communicate	**Words and phrases** **Changing Others by Changing Yourself** A lot of us wish that the person we are in conflict with, or feel intimidated by, would change. E.g.: 'If only she'd stop complaining about my work, I'd be much happier.' If you take away the 'if only' excuse, you also take away the need to blame and make the other person wrong. It also gives us the ability to take charge of most situations and make them all right for ourselves rather than waiting for someone else to change. **Assertive behaviour is a way of life** – the way you think and feel about yourself and others; the image you portray through non-verbal communication and body language; being able to 'read' others and respond appropriately. **Direct, assertive communication** Express yourself concisely and clearly in a direct, honest and spontaneous way. Avoid technical words, acronyms or jargons which are outside the comprehension of the listener. Consider aspects such as education, status and social standing; use language that the receiver will understand. **Be direct** State exactly what you feel or think; don't rely on your actions to tell the story. We often assume – especially with someone to whom we are	Lecture, listening and participating in discussion	Black Board, Exercises and Work Sheets	Specify the words and phrases to use while communi--cating assertively?

close – that they will know instinctively what we want, feel or need.

Tackle the problem not the person

There's a difference between 'Why can't you clear up after yourself' and 'Please tidy this workbench'. The former implies a character defect; the latter requires a solution to a problem. Both statements leave an impact on the recipient.

Deal with specifics, not generalisations

Compare 'You're always late' with 'Why were you late again this morning?' It's unlikely that someone is always anything! Be specific about the problem.

"Don't Accuse State Facts"

Don't over-apologise

'Yes, you can apologise enough. Once is enough if sincerely said and in an assertive manner. How often do we say things like 'Sorry, but I can't work late tonight' when we are not sorry at all? 'No, I've another appointment; I can't work late tonight' is far more direct, accurate and secure from further debate.

Be selective and sparing with your 'Sorry'.

Don't give excessive explanations

A brief reason for a request or refusal, or a short explanation of a statement softens what could otherwise be a blunt message. Don't go over the top with justifications, or become defensive. We could be

		confusing or upsetting the other person. **Take ownership of your message** 'I' statements assert that you take responsibility for your own thoughts, feelings and needs. You give the other person very little ground for debate. ➢ 'I need …' ➢ 'I feel hurt when …' ➢ 'I am not going to …' ➢ 'I will… but only if …'  By using 'I' statements, no one can argue with how you actually feel. **Honesty** Honesty entails asserting your needs and feelings as they are, not as other people feel they should be. Try statements such as 'I understand why you feel that I shouldn't be upset by this, but I am'. **Directives and requests** A teacher in a primary school found she had a basic communication problem with one of the children who brought up from a different culture. When she asked 'Would you like to close that window for me' he said 'No, thank you' – a perfectly logical response to a poorly phrased request. He was not being rude; he merely had a less sloppy command of the English language.			

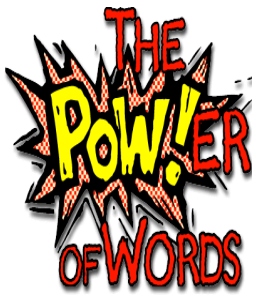
30 mins	practice the art of sweeter way of saying 'No'	**Spontaneity** The most difficult aspect of assertiveness to master is spontaneity as most often our gut reaction is either avoidance or aggression. The assertive option seldom enters the equation as it doesn't come naturally – it's a skill which has to be practised until it becomes as second nature. **Now and then** **How assertive are you?** Assertiveness is a choice of behaviour and that there are occasions when it is appropriate not to assert. It may depend on particular situation, your relationship with the person, your current mood, state of health, and so on. **Saying No- Not Nice Not Nasty** Here are some pointers of what could make it easier to say 'no'. ➢ Do not smile. ➢ If someone comes over to your desk and you want to appear more in charge, stand up. It puts you on even eye level. ➢ Avoid encouraging body language, such as nods and ahas. Keep your body language as still as possible. ➢ Avoid asking questions that would indicate you're interested (such as, 'Does it really have to be done by this afternoon?' etc.) ➢ **It's all right to interrupt!** Say something along the lines of, 'I'm	Role plays, listening and participating in discussion Discussion and participating in discussion	Video Shows, Black Board, Role plays, Work sheets Black Board, Exercises and Work Sheets	Outline the pointers in sweeter way of saying 'No'?

30 mins	deliver the message with power	really sorry; I'm going to interrupt you.' ➢ **Pre-empt**. As soon as you see someone bearing down on you, let them know: 'Hi there! I know what you want. You're going to ask me about a drink. Wish I could help you out, but I just can't.By learning more effective ways of saying 'no' you become more burglar-proof. **The sweeter way of saying 'No'** To add a slightly different view –you could try saying 'Yes' - but it with conditions attached. So for example,  ➢ 'Yes, I can do that. If you do XXX in return' ➢ 'Yes, on this occasion, to help you out, but after today I'm afraid I can't' **Power** The word power can be used or abused in two ways: power of delivery or the amount of force needed for you to get your message across, and the concept of power over others. **Confident delivery** Some people have a natural ability to command attention and respect when they speak. It isn't a question of status, or the content of what they say. What they do have is resonance.	Discussion, role plays and participating in discussion	Role plays, Video Shows	Explain the factors involved in delivering a message assertively?

People who speak quickly and breathily in a high-pitched voice do not appear as assertive as those who speak more slowly using deeper voice tones. The lower pitch conveys control and confidence.

Volume and intonation

Words delivered in a monotone soon become just that – monotonous! When you have given an assertive request in clear, level tones and that request is ignored, you have two choices: give up the fight and put up with the situation as it is, or make your request again, this time with a little more force. For example:



'Will you please tidy this work station?'

(Request ignored)

'Please tidy this work station.'

(request ignored)

'I want you to clear this work station – now!'

Position and status

Power can be tangible and visible to another before any words are spoken.

- How we greet others
- The handshake we give (and who offers a hand first)
- The spatial difference between individuals
- The orientation – whether face-to-face, right angle, side-by-side positioning

30 mins	display effective body language to communicate	➢ The layout of rooms, choice of furniture and so on, all reflect status and power  **Body talk** **Body language** **Aggressive body language** A typical aggressive stance is an erect posture with hands on hips, elbows pointing out. Facial muscles become tight. Movement will be tense. There may be signs of impatience such as rubbing thighs or tapping feet. They may invade your space, standing uncomfortably close. Eye contact is intense. Tone of voice is either louder or sometimes threateningly quiet. Volume and speed of delivery escalate with the level of aggressive behaviour shown. **Passive body language** A slumped appearance is typical of a passive person. A tight crossing of arms and twining of legs is seen. Facially an over-apologetic look, or signs of anxiety, like chewing the lower lip is often shown. The chin is drooped towards the chest, shoulders hunched. Blushing may occur. Movement may well be tense, agitated, and fidgeting. Tension may make them clumsy, spilling things. There can be a desire to maintain a physical distance. When seated, they may consciously pull elbows and	Discussion, Role plays and participating in discussion participating in discussion	Role plays, Video Shows	Demonstrate the implications of body language?

		knees towards the body in a hugging position. Gestures include clenched hands. There can be fiddling with hair, clothes, and pens and so on. Often the mouth is covered by the hand while speaking with a lot of face touching. They often find it hard to maintain eye contact. Their gaze will often be lowered and blink more often. Tone of voice will be quiet – in extreme cases there will be a nervous tremor. Speech may be hesitant with lots of 'umms', 'uhs'. There may be an apologetic whining tone. **Assertive body language** The assertive person has an upright, calm, open posture with hands hanging loosely at the sides or in the lap. There will be little crossing of arms and legs. Facial muscles too, will be relaxed. The assertive person greets the other with a genuine smile. Movement will be steady, regulated and relaxed. An assertive person will tend to lean towards the other person, but will keep the head erect. They will be comfortable with closer proximity. Gestures will be appropriate to the conversation with no excessive mannerisms. Eye contact will be direct and regular. The tone of voice will be appropriate to the situation; evenly pitched and steady.			

30 mins	specify the importance of assertive listening	**Now see hear** **Listening** Listening is important in assertive communication as it may be improved through listening skills. Improving listening skills will help others to pay the attention you deserve. Listen attentively to newscasters or to factual documentary programmes on TV or radio. Use an audio- or videotape to record about ten minutes of talking. See how much you can remember. **Conflict resolution** Improved listening skills can help to resolve conflicts. Engage the other person in conversation to establish their point of view. Question calmly; Where and how do these differ from your feelings, needs or wants? Express these clearly and rationally. If it is obvious that you are really listening to the other person – hearing, understanding and empathising with their point of view (even if you don't agree with it) – conflict can be resolved, in an adult manner, with minimum of stress to both parties. ***'Nothing is quite so annoying as to have someone*** ***Go right on talking when you're interrupting.'*** ***(Anonymous)*** **Deal with the emotions first!** Calm the person down if possible. "Give them 'time out' to talk."	Lecture and listening	Work Sheets, interactive exercises	Analyse the importance of listening assertively?

		Listen carefully and respond with empathy and ask questions about the specifics of the problem. Let them know you are hearing their concerns. E.g., "I understand why that would bother you…", "Can you tell me more about that?" **Restate the issue so they know you have heard them.** Be as objective as possible. Use the words told by them. **Consistent non-verbal's that match your verbal messages.** Don't apologize. Don't be shy; be confident in what you have to say. Don't be overly aggressive with you opinion relative to theirs! **Challenge them to shift a bit and look again at the issue.** "I see your point, but I need to challenge you to think about the way you delivered your message just now." "Have you considered their side of things?" **Reach agreement if possible and let them know what to expect in the future.** Offer choices or alternatives that don't distract from other's rights. Review your expectations for future behaviour or problem-solving tactics. **Rules for avoiding conflict** ➢ When others express different views, don't tell them they are wrong ➢ When criticized, ask for more information before responding 			

30 mins	utilize assertive strategies in relationships	➢ When criticized fairly, show you are willing to change your behaviour ➢ Don't get angry when telling others their behaviour causes you problems ➢ Agree to do reasonable requests **Relationships** People like people, who are like themselves, so if you can show within the first few moments of meeting someone that you are on their wavelength, they will listen and respect you. **Matching** If you are meeting someone for the first time, demonstrate your assertiveness by confident posture, smiling, eye contact, and maintaining an approachable demeanour. Learn quickly to identify the sort of language the other person prefers to use (formal/ serious/ chatty approach). Whatever their preferred style, adapt accordingly. **Mirroring** Modify your position and facial expressions to be more in tune with the other person's posture and communication will become easier.	Lecture and listening	Role plays	How to use assertive strategies in relationship?

30 mins	execute assertive strategies in dealing with problem people	**Relationships with relatives** To express yourself assertively with relationships because you have an underlying albeit unconscious belief that whatever you do or say, he or she will understand and accept you. Put yourself in their shoes or any other courtesies you would offer a work colleague, boss or even a comparative stranger. It is important to offer praise and encouragement and not take things for granted. **Problem people** **The irate** If you're natural reaction to an angry person is to rise to the bait, step outside the situation. Acknowledge that the anger is there: 'I see that you're really angry – I would be too if I were in your position…' Pace his anger, lead him into quieter waters by non-judgemental acknowledgement of feelings; you can go on to question carefully to ascertain the cause of the problem. When you are both on an even keel again you can assertively negotiate a way forward. If the other person refuses to calm down, you can assertively say something like 'This is getting us nowhere; I'll talk to you about this tomorrow' and then leave the situation. **The stayer** This is the person who talks on and on. Wait for a suitable pause and say something like, 'It's good that you called in today because we've	Lecture, Role plays, discussion and listening and participating in discussion	Work Sheets, interactive exercises	When to use assertive strategies?

		been able to catch up on old times, but I've got to prepare for my next meeting now…' Get to your feet, offer a hand if or walk past them to the door, leaving them in no doubt that the conversation is at an end and you wish them to leave. **The rabbit** These people never get to the point. Here you need good questioning skills so that you can interrupt in a constructive way. Reflect back for clarification, summarise occasionally, and ask further questions keep on track. **Your boss** Use all your assertiveness skills when communicating with your boss. For example, stand tall with head up and look alert. Maintain good eye contact. Be clear and concise. Use 'we' and 'us' to show you are part of a team. Maintain a pleasant and approachable demeanour. Know when to leave. Always thank your boss for the support, and offer praise when appropriate. **The critic** There are many types of criticism from positive, constructive feedback to destructive verbal attacks. It can be delivered in an assertive or aggressive manner. ➢ First step is to recognise the criticism			

1 hour	apply assertive strategies in tricky situations	➢ Honestly decide whether or not there is any truth in it ➢ Decide how to handle the criticism: agree, partially agree, or disagree ➢ Remember that it is the content of the criticism which has to be addressed, not how it is phrased or what you think is implied by your critic. **Fogging** With fogging, one is not necessarily agreeing with the criticism, but acknowledging that the other person may have a point. Offer no resistance, so the other person has nothing to argue against. Become comfortable with fogging, can cause the anxiety associated with receiving criticism to disappear. It goes something like this. **Tricky situations** **Yes and no** **Making and refusing requests** Once if decided with what you want; you need to convey this assertively saying 'I would prefer it if …'/ 'Would you please help me with …?' Make a positive 'I' statement. Ensure that your tone of voice, volume and non-verbal communication appropriately reflects your strength of feeling about the issue.	Lecture, Role plays, discussion and listening and participating in discussion	Work Sheets, interactive exercises	When to use assertive strategies?

		Broken record technique You could adopt the 'Broken Record' technique whereby you keep repeating your message until the other person accepts your point of view. First, be sure in your own mind about what you want or don't want. State your case clearly and concisely. Maintain assertive, relaxed tone and volume as you persistently keep repeating your point. Close the interaction by reiterating your assertive statement and getting agreement. Give a brief reason for your refusal or an apology, if you are genuinely sorry, for not being able to agree to their request. The key is to be empathetic, but persistent. **Giving criticism** Choose the time and the place carefully. If other people are present, go somewhere quiet and private for the communication. Ensure that you have enough time to talk things through. Offer the feedback immediately. Preface your communication with a remark on something good about the other person's work or attitude. Use 'I' statements. Specify exactly what the person has done which bothers you. Don't generalise. Comment on behaviour, not personality. Use silence. Be persistently explaining what you want in the way of alternative behaviour. Try always to end on a positive note.			

1 hour	demonstrate assertiveness in quitting alcoholism	**Compliments** Acknowledge efficient work; thank people who take time to listen; praise initiative; recognise extra effort. If you receive a compliment, acknowledge it gratefully as a 'gift' from the other person, e.g., 'Thank you – it was a Christmas present from my son. I like it too.' **Assertiveness in alcoholism** **Identification and modification of the antecedents** In alcoholics usually the drinking behaviour has certain special antecedents. In a behavioural management program, it is essential to identify and modify these antecedent factors. Usually these factors include the place of drinking, the time of drinking, the people with whom he drinks emotional factors and other environmental cues.  **Drinking places** Each individual will have a special place where he consumes alcohol. This can be any place like a bar, movie hall, a wine shop, a friend's house, a room in the factory, a special room, in the house or a meeting place of his drinking companions. If such a place can be identified, then the client should avoid these places to control and give up his drinking.	Lecture, Role plays, discussion and listening and participating in discussion	Work Sheets, interactive exercises	How assertiveness is used in alcoholism?

Drinking time

Usually the alcoholics have a specific time of the day, when he ingests alcohol. This can be evening, after work or the lunch hour in the afternoon or in the night, in home after everyone goes to sleep. If this 'favourite' time can be identified then, then alcoholics can be advised to develop other alternative behaviours and then urge to drink can be controlled. Alternative behaviours can be playing with children, going out with wife for shopping etc.

Drinking companions

Every alcoholic mostly has his own 'clique' with whom he drinks. These individuals can be friends, colleagues, relatives/ others. If solitary drinking is not predominant, the client is advised to avoid these friends at least in the initial phases of treatment. This was done to help him avoid the stimulus cues for drinking and also to ease the client off from the social pressures to drink.

Social events

Many a times, the clients indulge in drinking and is also pressurised to drink in some situations like to club / parties / in any social gathering. He is asked to avoid such gathering, so that he can have a control over his urge to drink.

		Emotional factors Alcoholics often report that they drink excessively to forget or to overcome some unpleasant emotions caused during some stressful situations. These negative emotions can be anger, depression, frustration or any conflict. During such severe emotional crisis he is asked to avoid drinking places, develop alternative behaviours / talk it out with some people he likes. The client is encouraged to meet the therapist and talk it out with some people he likes. The client is encouraged to meet the therapist and talk out the conflicts and not to approach any situation in which he gets strong urge to drink. **Other environmental factors** These can be like the way in which he travels and a bar/ a wine shop on the way. The very sight of such a place makes the urge to drink more strong. In case he comes across such a cue, he is asked to think about the negative aspects of drinking and to distant himself by hurrying him to imagine a pleasant scene at his home because of his abstinent behaviour. An alternative behaviour to curb his urge also to reduce his chances of drinking in the initial phases of treatment, he is asked not to carry much money with him and also not to share alcohol at home.			

		Environmental manipulation: **At home:** Client is asked to remove all the drinking cues from his house. These can be the alcohol bottles, drinking glasses/ any other paraphernalia's associated with drinking, not to store any alcohol at home even in the refrigerator. Also he is asked not to invite any guests who drink alcohol. This is very crucial in the initial stages of recovery. **At office:** If he takes alcohol everyday with his colleagues / on the way from his work place then those have to be avoided. The client is asked to assert himself amongst his drinking friends that he has given up and to avoid such company for some time during the initial recovery period. Also he is asked to change his routine, so that antecedent cues can be controlled. Also he is asked to take a new and different way back to his house. This helps in avoiding the sight of the bar or the wine shop. **Development of alternative behaviour** **At home:** It is seen that generally the chronic alcoholics indulge in drinking usually during leisure time. To avoid this, he is asked to develop alternative behaviours at home so that this maladaptive behaviour pattern is broken and his interests are channelized into other behaviours. The alternative behaviours can be,			

		➢ To spend more time with the family members, help the children in studies or to sit with them and talk about the day to day affairs. ➢ If possible to sit with family members and eat dinner together in the night. ➢ If evening causes boredom without drinking, the client is advised to take children for an evening stroll and involve himself with the children. ➢ To make it a point to go along with his wife for shopping and to take an active interest in the household chores. ➢ To organize picnics and outings with the family members and he gets into a pleasant frame of mind. **At workplace:** Regarding alternative behaviours to be developed at the workplace / at office area; ➢ To develop assertiveness and friendship which is drink free. ➢ To concentrate more on the work and to enhance his output and efficiency. ➢ To involve in some of the recreational and in the social and cultural activities in the office which might be organised by the company and his associates.			

1 hour	resist pressure to drink alcohol	**Within himself:** With regard to the client himself, he is advised to involve himself in some interest/ hobbies. If he has had a previous hobby, then he is asked enhance his interest / to develop new ones with in his socio cultural milieu. The hobbies / interests may be ➢ Reading books ➢ Physical exercises like some games / in some sports activity. ➢ Start new venture like gardening, house décor, helping the children in their activities etc. ➢ Any activity in which he was interested before the onset of his drinking problem. **Drinking refusal skill training** This is the phase in which the client is given assertiveness training. Many a times it is seen that alcohol intake is due to social pressures. The individual finds himself not being able to refuse drinks because of his friends' compulsion. Also they worry about the consequences if they refuse to join the drinking group. The different aspect of assertion is impacted to the client. The basic model followed here is from the training developed by Salter and his co-workers. The components of this training method includes various aspects of verbal, nonverbal communication patterns, usage and efficacy	Lecture, Role plays, discussion and listening and participating in discussion	Work Sheets, interactive exercises	How to resist the pressure to drink alcohol?

		of facial expressions, gestures and postures and how to use this for an easy but efficient communication. The clients are advised on the following factors; ➢ To be assertive while informing friends that he has given up drinking ➢ Not to feel guilty or embarrassed while telling this fact ➢ Prepare the client on the fact of different reactions that he may get from his drinking friends. Some may make fun or make faces or they may ridicule the client. The client has to be prepared for this because otherwise it can lead to weakening in his resolution and his motivation to give up drinking ➢ To let everyone know that you have given up drinking. This fact should not be hidden or lied. ➢ When questions come up, there is no need to give any logical explanations or rationalise the fact of you giving up drinks. ➢ To avoid places and sittings in which a chance might be present of you yielding to pressures ➢ In the company of new people, just inform them that you do not drink and not that you have given up drinking The drinking refusal training was conducted with behavioural rehearsals and role playing in the clinic. The different components of			

		these were ➢ Informing ➢ Resisting ➢ Suggesting alternative behaviours ➢ Redirecting and ➢ Threatening  **Informing** This is to assert himself that circle of friends that you have given up drinking and not to force you to drink. This should be told in a convincing and a firm manner. **Resisting** Repeat your insistence that you have given up alcohol completely and is not going to join them and drink any more. Also that nobody should force you to drink. **Suggesting alternative behaviours** Suggest the venue or the place of gathering to be in a coffee shop or in a restaurant which does not serve alcohol than to be in a bar or a wine shop. Request them to join you for a coffee or tea. Emphasize the fact that you want to be with them but have the meeting in a coffee shop.			

		Redirecting If your friends insist on you joining them for a drink then try to change the topic and conversation. The talk can be directed to some other topic like family or work or recreational activity which all of them would be interested. **Threatening** Even after other steps, if your friends are still insisting on you join them for a drink then threaten that you would not mind in breaking the relationship with the group if they insist. Quit the place by refusing the offer.			

Exercise 1:

How might you use your hands, in relation to your face, to indicate the following emotions to the other person:

- Real Interest
- Scepticism
- Boredom
- Confusion

Comments

There are many variations on a theme here, and I wouldn't suggest for one moment that you study the subject of body language in order to manipulate situations to your advantage. However, here are some suggestions regarding how you might have used your hands to indicate the above emotions.

- Hands steeple against lips with possible accompanying.
- Concentrated expression and nodding of head;
- Forefinger above lips with rest of hand cradling chin; or tugging an ear lobe;
- Chin resting in fisted hand;
- Rubbing of forehead.

Exercise 2

Consider this scenario. Bill and John meet in the office corridor.

'John! I haven't seen you for ages; how's business?'

Handshake, Bill offering right hand, placing left on John's shoulder.

'Business is fine … etc.'

John talks for a while about his new project.

'Great talking to you John; we must have a dinner together again sometime.'

Bill backs away, turning to leave the conversation.

Of the two, who is the managing director of the company and who the visiting supplier wanting to do business?

Bill is more likely to be the MD at home on his own territory, and John the visiting supplier, wanting to do business with the organisation. The clues are who initiated the handshake; the physical touching; who indicated that the conversation was at an end by backing or turning away.

Exercise 3

Tom: You made a real mess of that interview

Harry: You may be right; I could have handled it better.

Write the responses for the hypothetical questions

Your boss: You are not pulling your weight.

You: _____

Your co-worker: You're too lenient with your staff.

You: _____

Your partner: You never do anything I want.

You: _____

Exercise 4

Solving shared problems

Purpose

This activity demonstrates the importance of sharing problems with team mates and shows an effective way of receiving a collection of different solutions for a particular problem.

Objective

A problem solving exercise which encourages participants to share their problems with their team mates and receive a collection of different solutions from them.

What You Need

- A4 paper for each participant.
- White board

Setup

- Ask each participant to write down on their paper a current problem they are facing at workplace. Give delegates 3 minutes for this part of the activity.
- Collect the papers from delegates and write one of them on a flip chart or whiteboard.
- Ask each delegate to come up with a solution or advice for that problem.
- Repeat this procedure until all the problems have been addressed.

Timing

Explaining the Exercise: 2 minutes.

Activity: 3 min coming with problem + 15 min on solutions = 18 minutes

Group Feedback: 10 minutes.

Exercise 5

Collective drawing

Purpose

A creative and fun exercise, this activity shows the importance of communication and team work in successfully completing tasks.

Objective

Team members to collectively design and draw a particular object.

What You Need

- A sheet of paper for each team
- A marker pen for each participant
- A whistle

Setup

- Split the group into teams of 3 to 4 people. Give each group a sheet of white paper.

- Explain to teams that they should draw an object chosen by you in 5 minutes. Examples of objects include an aeroplane, a computer, an alarm clock and so on.
- Explain that one participant in each team should start drawing after you blow your whistle.
- The participant should stop drawing as soon as he hears the second whistle. He should then pass the sheet to one of his team mates. Continue with this process as you hear the whistle.
- Team members can help their colleagues by giving them instructions about their drawings. At the end of 5 minutes each team should explain their drawings to others.

Timing

Explaining the Exercise: 5 minutes.

Activity: 5 min drawing + 5 min sharing minutes = 10 minutes

Group Feedback: 10 minutes.

Exercise 6

My name stands for:

Purpose

This is a fun ice breaker especially suitable in new teams where people are not very familiar with their team mates.

Objective

Delegates to describe their personality, habits, hobbies and dreams using the letters in their name.

Setup

- Each delegate has 5 minutes to come up with a number of adjectives which best describes their personality, habits, hobbies and roles using the letters in their name.
    - Example: **DAVID** can stands for **D**ad, **A**ble, **V**alue, **I**nteresting and **D**ancer.
- After 5 minutes, ask each participant to introduce himself/herself to the group and explain what the characters in his/her name stands for?

Timing

Explaining the Exercise: 2 minutes.

Activity: 5 min exercise + 5 min sharing = 10 minutes

Exercise 7

Judge me at my face value

Purpose

This interactive exercise allows participants to realise the effect of generalisation and discrimination.

Objective

Delegates to use premade labels in treating their team mates in a certain way.

What You Need

- A number of white stickers or Post It notes to the number of participants.
- On each sticker write a command such as:
    - "Respect me"
    - "Ignore me"
    - "Laugh at me"
    - "Argue with me"
    - "Don't take me seriously"

Setup

- Ask delegates to stand in a straight line and stick one of the stickers over the forehead of each participant. Delegates cannot see their own stickers and should not tell others what their stickers are.
- Split the group into teams of 3 to 4 people. Explain to all delegates that they should treat their team mates according to the command on their stickers at all times.
- Ask each team to organise a business trip abroad for the whole team. They have to discuss flights, transports, hotels and conference materials for this trip. Allow 10 minutes for this discussion.
- After the allocated time, bring all groups together and ask them to share their experience.
- Follow with a discussion.

Timing

Explaining the Exercise: 10 minutes.

Activity: 10 min group activity + 10 min sharing experience = 20 minutes

Group Feedback: 5 minutes.

Exercise 8

Who is your great leader

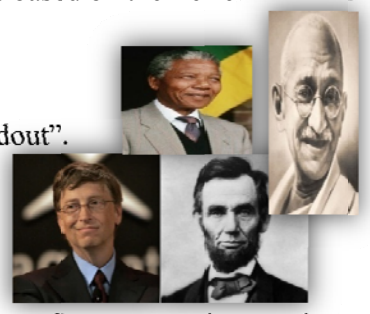
Purpose

Many people still confuse the distinction between a manager and a leader. One of the best ways to understand this difference is to study the great leaders in history and recognise why they were so good at what they did. By focusing on examples, the delegates will quickly learn the critical qualities of a great leader.

Objective

Identify a number of Great Leaders for different scenarios based on their effectiveness.

What You Need



- Distribute the "Who is Your Greatest Leader Handout".
- Flipchart

Setup

- Ask the participants to fill in the form, "Who is Your Greatest Leader Handout".
- Delegates must choose a leader of their choice for each question in the form based on their understanding of the leader's capabilities and leadership style. They should also indicate why they chose that leader.
- Once finished, initiate a group discussion and allow the delegates to share their choice of leaders for each scenario.
- Identify qualities that are repeated among leaders and discuss the importance of these qualities with the delegates.

Timing

Explaining the Exercise: 5 minutes.

Activity: 15 minutes

Group Feedback: 15 minutes.

Exercise 9

Team building exercise: Empowering questions

Purpose

This questioning activity allows participants to draw positive comments from their team mates and to share their happy experiences as team members with others. The exercise therefore boosts teams' morality and creates a positive atmosphere within the team. This activity is designed for a group of participants who work together as a team.

Objective

Participants to follow a number of randomly assigned questions and commands in the presence of their team mates.

What You Need

- A number of folded A5 sheets of papers according to the number of participants with one question or command per sheet. Examples of questions/commands include:
    - "Who do you feel most comfortable working with in your team?"
    - "Pick 2 people in this group to pay you a compliment."
    - "Who is the best problem solver in this group of people?"
    - "Who would you respect most in your team and why?"

Setup

- Ask participants to sit in a circle.
- Give one folded sheet of paper to each participant.
- Starting with the participant on your right, ask each delegate to read the statement on their sheet aloud and respond to it.
- Repeat this procedure for all the participants.

Timing

Explaining the Exercise: 5 minutes.

Activity: 15 minutes

Group Feedback: 5 minutes.

Role play 1

You and your friend share a car. You have agreed to pick up a colleague to go to an evening meeting and have assumed that you will use your shared car. On arriving back, your friend says that she has to go for a party, and needs the car to get to the club. Suggest solutions to the situation against the areas listed below:

1. Avoidance
2. Win–lose
3. Compromise
4. Win–win

Comments

1. You could just give in, suppressing your own needs. By implication, your friend will have 'won', but lowered self-esteem and resentment towards the other person may result.

2. You could argue that your need is greater than hers and take the car. There will always be a winner and a loser but invariably the relationship will suffer as a result.

3. You could suggest that you take the car to the meeting, but will pay for a cab for your friend. At worst, both of you may feel cheated and dissatisfied with the outcome.

4. You could suggest a solution where both of you 'win', by dropping your friend at the club before going to the meeting and collect them when business is finished. A win–win solution is not always possible, but should always be sought.

Role play 2

Consider the following situations. Role-play each beginning with an assertive statement. Ask your colleague to ignore you or give some sort of excuse rather than agree to your request. Persist, increasing verbal and non-verbal intensity.

1. You see that a colleague is using your personal calculator. As the calculator was in your briefcase, you know that she has gone through your property. You feel this is an invasion of privacy and don't want it to happen again.

2. You are trying to watch a TV documentary. Your partner/son/daughter is playing loud music in another room. You need the volume turned down in order to enjoy your programme.

Role play 3

Here you will need the help of a friend or colleague. Ask her/him to choose from the following situations and role-play the person making the request. Your task is to refuse steadfastly, using the Broken Record technique

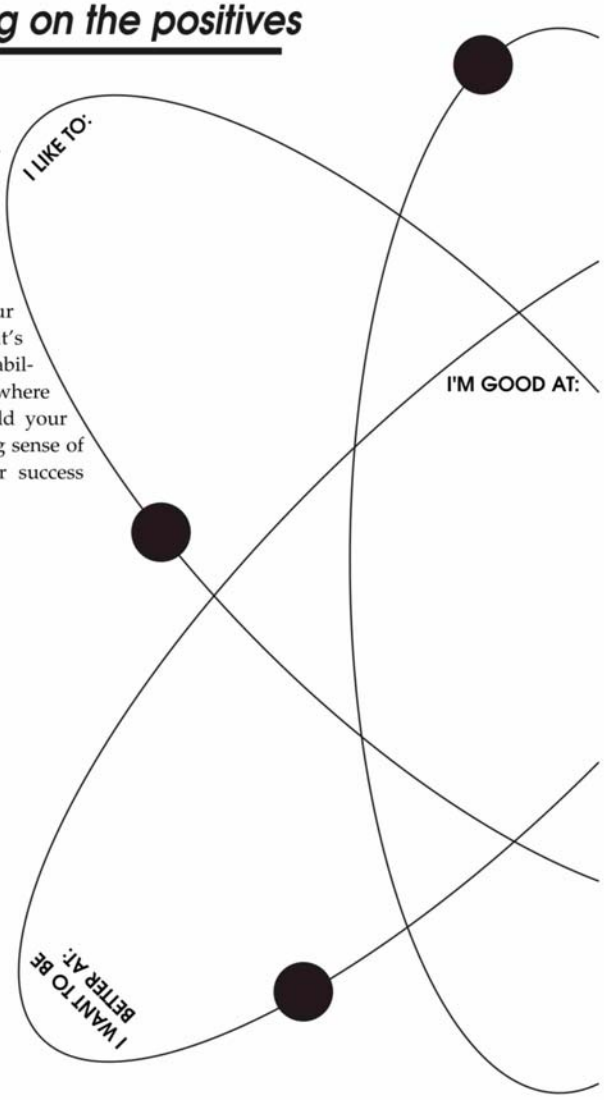
A colleague says: 'How about going out for a drink tonight, after work?'

Work sheet 1

Focusing on the positives

Every individual has a different set of abilities. Where you do well, another person might fail. Likewise, something that comes easily to another person might be difficult for you.

No matter what your strengths and weaknesses, it's important to believe in your own abilities. When you focus on areas where you are successful, you will build your self-confidence. And with a strong sense of self-confidence, your chances for success and happiness will be greater.



ACTIVITY I

Using the diagram at right, make a list of things you like to do, things you're good at, and things that you'd like to get better at. Look through the newspaper for words and phrases to add to your list and pictures to help illustrate your thoughts.

Work sheet 2

Getting rid of the negatives

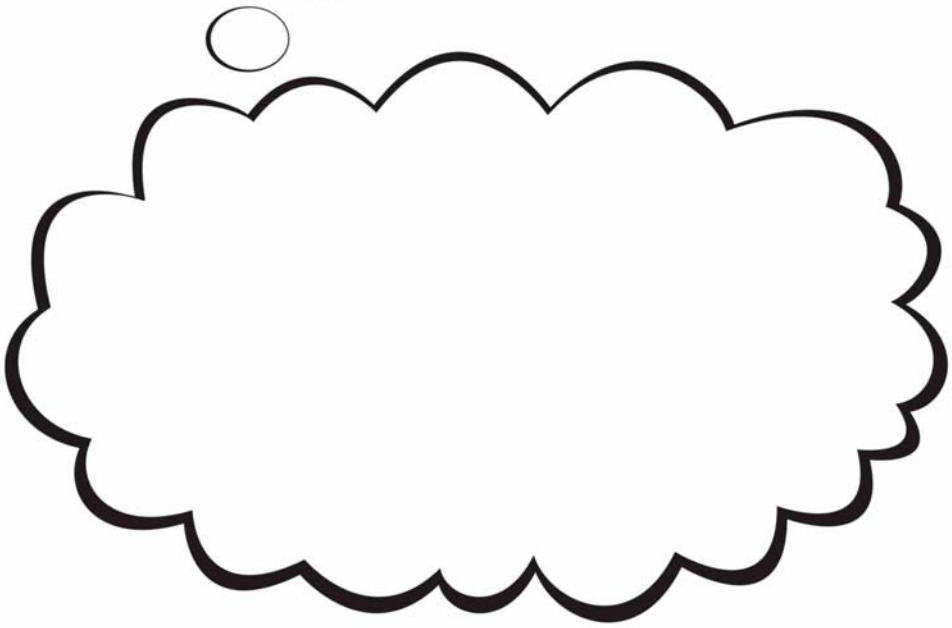
Like everyone else, you have negative thoughts and feelings — fear, insecurity, guilt, and even hatred. But also like everyone else, you have within yourself the ability to replace these "negatives" with a more positive way of thinking. It may not always be easy, but it is possible!

ACTIVITY I

One technique often recommended for getting rid of negative thoughts and feelings is to replace them with mental pictures of peaceful scenes, such as the light of the moon on water, the ocean washing gently on the sand, or the stars twinkling on a clear, quiet night.

Think of a peaceful scene you could use to prevent negative thoughts from creeping into your mind. Describe that scene below.

A PEACEFUL SCENE



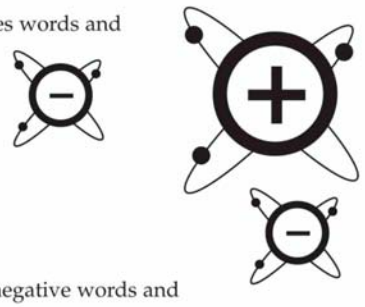
Sometimes, simply thinking of peaceful words and expressions might do the trick. Using today's newspaper, find and circle at least 10 "peaceful" words and expressions to tuck away when you need a little peace of mind.

Work sheet 3

Getting rid of the negatives

Are you a user of "little negatives"? Do such phrases as "I don't think I can do that" or "I'm afraid I'll be late" clutter up your conversation?

You may not even realize it when you use negatives words and phrases. Regardless, if you use them enough, they can condition you to think negatively, too. Before you know it, little negatives will clutter up your mind, as well as your conversation.



ACTIVITY II

Everyone is guilty of using little negatives once in a while. Write down four examples of negative words and phrases you have heard or have used yourself.

1.

2.

3.

4.

Using your newspaper, identify quotes in which someone used little negatives. Below, write the sentences containing the negative words or phrases. Discuss the effects they might have on the people saying them.

Work sheet 4

Finding happiness

There are a few basic principles of happy living, such as a showing kindness to others, having a friendly attitude, sympathizing with someone's sorrow, and showing sensitivity to others' feelings. If you base your actions and attitudes on such fundamental principles, your chances for happiness will greatly increase.

Here are some other basic principles of happy living:

- Keep your heart free from hate
- Keep your mind free from worry
- Live simply
- Give much
- Forget thinking of yourself and think of others
- Treat others as you would like to be treated

Can you think of others to add?

ACTIVITY III

In small groups, create the ideal comic strip character — one that exhibits all or some of the attitudes and positive actions mentioned above. Begin by writing the name of an existing character from your newspaper that exhibits the qualities listed below.

A character that keeps his/her heart free from hate: _____

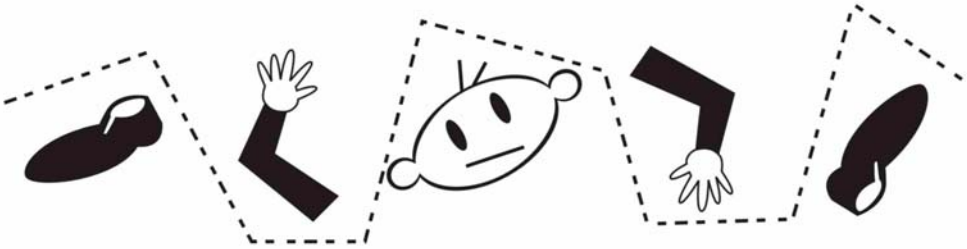
A character that keeps his/her mind free from worry: _____

A character that lives simply: _____

A character that thinks of others: _____

A character that treats others as he/she would be treated: _____

Now, draw your character or "piece" it together by using the head of one comic strip character, the body of another, and so on. Be sure to give him or her (or it!) a name.



Work sheet 5

Focusing on the positives

People with positive attitudes believe they have within themselves the ability to overcome many obstacles. No matter what life hands them, their ability to think positively gets them through even the most difficult situations.

"Attitudes are more important than facts," according to famed psychiatrist Dr. Karl Menninger. If you have a defeatist attitude, then you believe you're a failure whether you really are one or not.

ACTIVITY III

Think of a situation that has you worried. Write a sentence describing that situation. Then make a list NOT of the factors that are against you but the factors that are for you. It may surprise you how many positive things you really have going for you.

A situation I'm worried about:

What I have going FOR me:

Now, try this same exercise with a situation covered in your newspaper. Identify a person who is struggling with a crisis or problem. On a separate piece of paper, make a list of the factors or attitudes that might help this person get through the situation successfully.

Handout 1

Ways to Enhance Self-Esteem

Your Appearance

Research shows that people determine seven things from your appearance:

- ✓ Income
- ✓ Education Level
- ✓ Social Position
- ✓ Sophistication
- ✓ Success
- ✓ Moral Character
- ✓ Trustworthiness

Ways Your Thinking Can Be Distorted

- ☹ All or nothing thinking
- ☹ Overgeneralization
- ☹ Mental filter
- ☹ Discounting the positives
- ☹ Magnification or minimization
- ☹ Emotional reasoning
- ☹ "Should" statements
- ☹ Labeling
- ☹ Blame

Get What You Want

- ✓ Ask clearly. Be precise. Think about your request. Take time to prepare—maybe even write out what it is you want and practice. Words are powerful so chose them carefully.
- ✓ Ask with confidence. You are more apt to get what you want if you speak up and sound confident rather than hesitate and sound unsure of yourself. The worst that can happen is that you will be denied, but it probably won't put you in a worse situation than before. If this route is closed, look for another.
- ✓ Ask creatively. What can you do to make sure you make an impact, and to make certain your request doesn't get lost in the crowd? How could you make your request stand out? How can you make your request fun? Schedule some time every month to dream up new and different ways to ask for what you want.
- ✓ Ask sincerely. When you really want help, people will respond. Be willing to be vulnerable, and tell it the way it is, lumps and all. Don't worry if your presentation isn't perfect; ask from your heart.

Creating the Right Impression

Bad impressions could be created from:

- X Being grouchy or surly
- X Bad breath
- X Chewing gun
- X Clothes dirty, torn, rumpled, stained, too tight
- X Jacket sleeves that are too long, pant legs that are too long, shirt sleeves that are too short or shirts/blouses that are too tight
- X A voice that is too soft or too loud, too uncertain or too boastful.
- X Playing with your hair, your earrings, or your moustache or beard

You could create a better impression by:

- ✓ Smiling
- ✓ Having a pleasant expression on your face when you meet others
- ✓ Don't chew gum in a setting where you want to look professional
- ✓ Making sure your fingernails are clean & manicured (men and women), meaning not too long or with chipped nail polish
- ✓ Ensuring clothes are neat, clean, and appropriate. Shoes should be polished and not run down at the heels.

Smile!

Studies have shown that people who smile tend to:

- ☺ Manage more effectively
- ☺ Teach others more effectively
- ☺ Sell more effectively
- ☺ Raise happier children

Did you know…

- ✓ Smiling exercises 16 muscles.
- ✓ Smile when you talk on the phone. It comes through in your voice.
- ✓ Smiling can be contagious.

Ways to Build Your Self-Esteem

There are many things we do to tear down our self esteem. However, there are also lots of things we can do to build our self-esteem up.

Tear Down	Build Up
X Constantly criticize our own actions	✓ Forgive ourselves for our mistakes
X Take the remarks other people make as personal attacks on us	✓ Be kind to ourselves and recognize that we won't always be perfect
X Tell ourselves we are stupid, or don't deserve better	✓ Use positive self-talk
X Compare ourselves to others and feel they are smarter, better, more attractive	✓ Compare yourself to yourself alone. Everybody is different and we each have our own talents and strengths
X Believe others are out to get us	✓ Believe that others are doing their best to get along, just like us
X Tease and torment others in an effort to make them feel badly too	✓ Do a kind act every day with no thought of a reward

Remember, of all the judgments you make in life, none is as important as the one you make about yourself. Without some measure of self-worth, life can be enormously painful.

Ways to Wipe Out Worry

- ✓ Postpone worrying: To do this properly, schedule a 30-minute worry break. As soon as you catch yourself worrying, tell yourself you'll really be able to worry about the matter at that time. When that golden time rolls around, sit down with paper and pen and worry to your heart's content. However, be sure to think your problems through completely, to the point where you figure out what you would do if catastrophe actually did strike.
- ✓ Be realistic about the downside: While you are sitting there with your paper and pen during your worry period, make yourself write out what could be the worst thing that could happen, regardless of what it is you are worrying about. Force yourself to be realistic about the possibility that that will occur.

How to Project Self-Confidence

- ✓ Pretend you are confident: Imagine yourself to be a confident person. Get that image in your mind and act it out. Project confidence. Stand up straight, dress better, and try to play the part.
- ✓ Monitor your self-talk: Listen to what those little voices are saying inside your head. If they are eroding your confidence, stop those tapes and put in new, positive messages.
- ✓ When you meet people, look them in the eye: Confident people do that. People who aren't confident don't.
- ✓ Smile: This can be a subtle sign of confidence.
- ✓ Listen: Confident people are generous enough with their time to listen to others.
- ✓ Know your stuff: Your confidence can't be all a front. While you are looking people directly in the eyes, standing straight, and otherwise acting as if the world were your oyster, you also have to know what you are doing. If you are prepared and sure of your facts, you've got a better chance of projecting confidence.

Handout 2

Communication Strategies

Seven Easy Ways to Say No

- ✓Say no, firmly and calmly, without saying, "I'm sorry," which weakens your stand.
- ✓Say no, followed by a straightforward explanation of what you are feeling or what you are willing to do.
- ✓Say no, and then give a choice or alternative.
- ✓Say no and then clarify your reasons. This does not include long-winded statements filled with excuses, justifications, and rationalizations. It's enough that you do not want to say yes. Your clarification is given to provide the receiver more information so that he or she can better understand your position.
- ✓Use your natural no. You may have developed your own style of saying no based on your past experience and personality. If so, use it.
- ✓Make an empathetic listening statement, than say no. You may paraphrase the content and feeling of the request, and then state your no.
- ✓Say yes, and then give your reasons for not doing it or your alternative solution. You may want to use this approach in situations when you are willing to meet the request, but not at the time or in the way the other person wants it.

Guidelines for Saying No

- ✓Say your statement firmly, calmly, and as unemotionally as possible.
- ✓Be aware of your nonverbal behavior, making sure you don't come across passively or aggressively.
- ✓Use plenty of silence to your advantage. Your silence will project the message that the other's statements and manipulation are futile.
- ✓Be persistent. Simply state your response one more time than the other person makes his or her request, question, or statement.

Thirty Ways to Persuade

1. Learn to link/connect with individual clients.
2. Demonstrate your expertise and knowledge.
3. Fair/Fair not Win/Lose.
4. Be consistent (predictable).
5. Make sure integrity is reflected in your standards/values/behavior.
6. Never assume they understand you.
7. Never assume they believe you.
8. Know when to be silent.
9. Tell the truth.
10. People believe exact numbers.
11. Show you have nothing to gain.
12. Flush out problems assertively.
13. Clients believe written words over verbal words. This finding reveals why telephone explanations can be challenging to present.
14. Create an obligation for one or both parties.
15. Proceed a bit at a time, inconsequential into major areas.
16. Practice diffusion ("out for the same things").
17. Never corner clients. Leave them a way out.
18. Give two options when both are acceptable to you; so that you win regardless of the choice. (Old sales trick!)
19. Play with innocent questions such as, "Why would you want to do that?"
20. Never accept an invitation to attack (trust issue).
21. Exude charisma, read the auras of individuals.
22. Everyone is important and unique. Some literature says that you should treat all clients like they were an interesting guest on a TV talk show.
23. Don't patronize.
24. Give sincere compliments.
25. Smile before you dial (or in person).
26. Be childlike (open and transparent). Expand your centre of interests to include others and explore the talents of others.
27. Use humor if appropriate.
28. Remember names.
29. Remember difficult people don't play by the same rules.
30. Practice strategic apologizing.

Body Language Tips

- ✓Eyes, eyebrows, and mouth send out the signals that can make a world of difference.
- ✓People who smile are happier than those who don't.
- ✓ Eye contact helps you carry your message to each person in the audience. It builds trust.
- ✓Learn to speak with your hands. Draw lines in the air, make a point, count on your fingers, and emphasize length and width.
- ✓Work on appearing sincere and comfortable.
- ✓Let your hands do what they want to do, as long as they don't get in your pockets, fiddle with an object, or make obscene gestures to your audience.
- ✓Your body posture affects your emotions and how you feel determines your posture.

The Three Stages of Active Listening

1) Non-verbal: These are the messages our body sends to others that tell them we are listening, like leaning forward, making eye contact, nodding our head, attending to what they say.

2) Cues: Those short phrases that keep us connected and tell the other person we are still listening. Examples:
   - OK
   - Go on
   - All right
   - You're kidding!

3) Using paraphrasing, clarifying, and summarizing questions. Ask questions to make sure you understand what is said.

Tips for Remembering Names

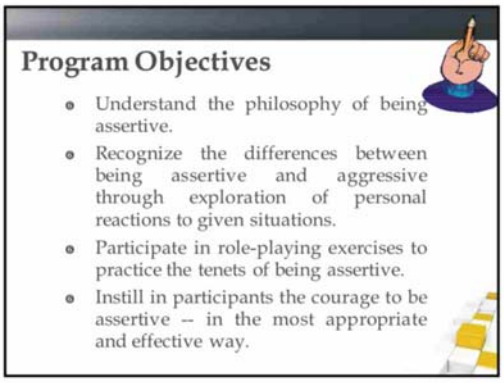
- ✓Concentrate.
- ✓Repeat the name out loud, right after you hear it. Try to find other opportunities to use it.
- ✓Get some kind of visual fix. (Matt has thick hair like a mat.) These are not things you are ever expected to share with the person so be as creative as you must be to remember visually.
- ✓Group associate. Know where you met the person. Perhaps write it on their business card if you get one.
- ✓Write the name down as soon as you can.
- ✓Pay attention. That's most important.

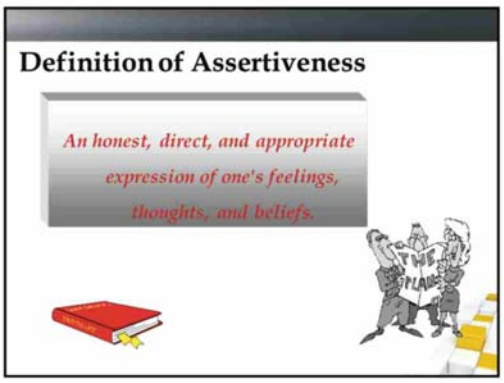
What's Your Body Saying?

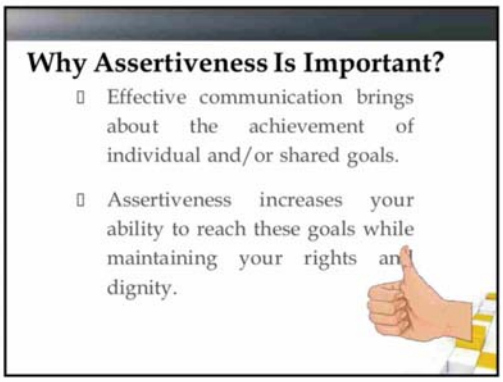
Non-Verbal Communication	Interpretation
Facial Expressions	
Frown	Displeasure, unhappiness
Smile	Friendliness, happiness
Raised eyebrows	Disbelief, amazement
Narrowed eyes	Anger
Blushing	Embarrassment

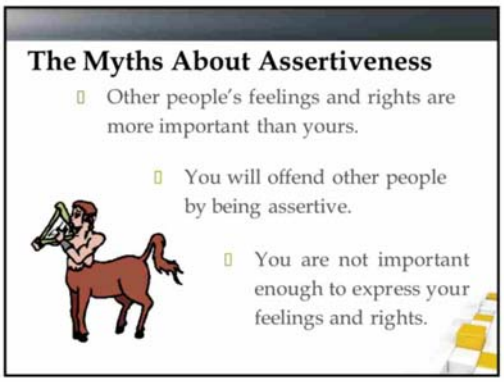
APPENDIX – XXI

POWER POINT PRESENTATIONS









Assertive Rights

- You have the right to be assertive.
- You have the right to request that others change their behavior if they are infringing on your rights.
- You have the right to use your own time to answer questions.
- You have the right to express your needs even if they are illogical.

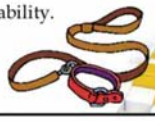
Be aware that there are responsibilities attached to all these rights!

Remember

- You do not live in isolation.
- Your actions impact everyone.
- You are in control of your behavior.
- Your response to a situation must be guided by ascertaining your rights and responsibilities and following through.

What's Keeping You From Being Assertive?

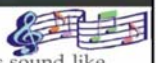
- Fear of change.
- Refusal to admit their submissiveness.
- Fear of ruining relationships if you speak your mind.
- Lack confidence in your ability.



Have You Ever Felt...

- ... guilty about saying "no"?
- ... that others regard you as a pushover?
- ... that it's better to be well liked than well respected?
- ... that outbursts of anger are appropriate?
- ... that intimidation is the only way you can get what you want?

Sound Familiar?



If any of these things sound like you, it means you are probably exhibiting non-assertive behavior.

Realize that you are not alone. Non-assertive behavior is very common in the workplace.

A Caution

While assertiveness is a key factor in enhancing quality of work life, group dynamics, and interpersonal climate, it is not always appropriate.

Q: *How can you tell?*

A: *Tailor your response to the situation.*

What Assertiveness Is

- Respect for yourself and others.
- Honestly expressing your thoughts, feelings, and beliefs.
- Effectively influencing, listening, and negotiating with others.

What Assertiveness Is Not

- It is important to remember that assertiveness is not aggressiveness or selfishness.
- Being assertive does not involve humiliating or abusing other people and their rights.
- Being assertive does not mean violating the rights of others or gaining at the expense of some one else's loss.

Aggressiveness Is

- Inappropriately expressing your thoughts, feelings, and beliefs in a way that violates other people's rights.
- Achieving your goal by not allowing others the freedom to choose.
- Completely disrespecting others whether it be in an active or passive method.

Acting Unassertiveness Is

- Acting in an indirect or passive manner.
- Permitting others to take advantage of you by violating your rights.
- Thinking that you and your needs are inferior to others and their needs.

What Would You Say?

- George is next in line to buy tickets in a crowded movie theatre lobby. Just as his turn comes up, a man cuts in front of him and requests tickets. George meekly steps back to allow the man room and hopes he gets waited on next.

A Passive Person

Passive people usually:

- Speak softly and hesitantly.
- Use fillers like "uh" and "um."
- Avoid eye contact.
- Allow other people in their personal space.

An Aggressive Person

Infringes on others' rights, using fear and intimidation to get what he or she wants.

Aggressive people often:

- Raise their voices when they lose control.
- Shout and use accusatory language like "You *should*" and "You *must*."
- Stare people down and may invade other people's personal space physically.

An Assertive Person

Asserts his or her own rights in a positive, open, honest, and self-confident manner.

Assertive people usually:

- Speak calmly and confidently.
- Notify other people of their feelings with statements starting with "I think" and "I feel."
- Maintain eye contact, have good posture and are poised and in control.

Assertiveness is Also About

Setting limits.

Expressing your feelings.

Don't Go Down the Passive or Aggressive Road

Passive Assertive Aggressive

Nine Types Of Assertive Response

- Disagree in both a passive and active manner depending on the situation.
- Always ask for answers when you have questions regarding any issues even when it is with a person of authority.
- Let other people understand more about you – let them share your thoughts and experiences.

Nine Types Of Assertive Response

- Be reasonable when you are in a discussion with others without letting them dominate the interaction.
- Say "no" to any requests you are uncomfortable with or feel is unreasonable.
- Always look directly into the eyes of the person you are talking to.

Nine Types Of Assertive Response

- Accept compliments graciously without feeling embarrassed or the need to depreciate yourself.
- Be friendly and sincere with the people you would like to know better; give them a chance to get to know you.
- Insist on being treated fairly and justly – never let others take advantage of you.

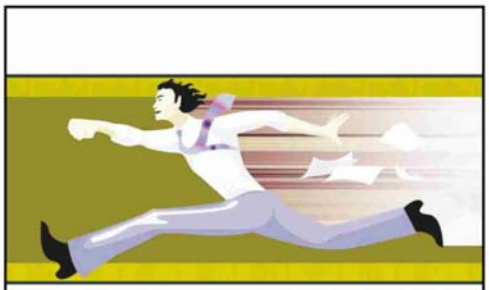
Developing to Your Full Assertive Potential

- Inside everyone, there's an assertive person trying to get out.

- What's keeping you back?

Start Out Small

Master what you can manage comfortably at first, then move up to greater challenges. Change is always gradual; it's not immediate, but it's not impossible either.



How to build your Self-Esteem???

Program Overview

- Self-Esteem…What is it?
- Self-Esteem…What's it made of?
- Types of Self-esteem
- The secret to improving Self-esteem

Self-Esteem…What is it?

Self-esteem refers to the way we see and think about ourselves.

Self-Esteem…What's it made of?

- Your self-esteem is made up of all the experiences and interpersonal relationships you've had in your life.
- Everyone you've ever met has added to or taken away from how you see yourself!

The Effects of High Self-Esteem

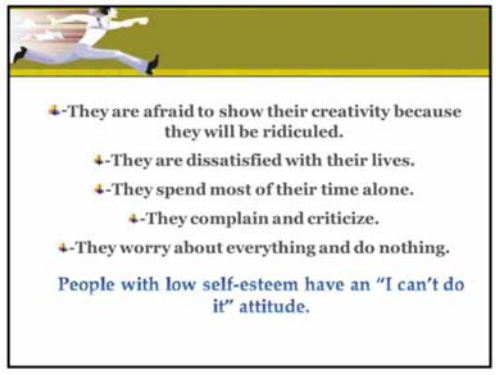
- People with high self-esteem possess the following characteristics:
  - They like to meet new people.
  - They don't worry about how others will judge them.
  - They have the courage to express themselves.
  - Their lives are enriched with each new encounter.

- They are nicer to be around.
- Their ideas are met with interest because others want to hear what they have to say.
- They are magnets to positive opportunities!

People with high self-esteem have an "I think I can" attitude!

The Effects of Low Self-Esteem

- People with low self-esteem possess the following characteristics:
  - They don't believe in themselves.
  - They see themselves failing before they begin.
  - They have a hard time forgiving their mistakes and make themselves pay the price forever.
  - They believe they can never be as good as they should be or as others.



- -They are afraid to show their creativity because they will be ridiculed.
- -They are dissatisfied with their lives.
- -They spend most of their time alone.
- -They complain and criticize.
- -They worry about everything and do nothing.

People with low self-esteem have an "I can't do it" attitude.

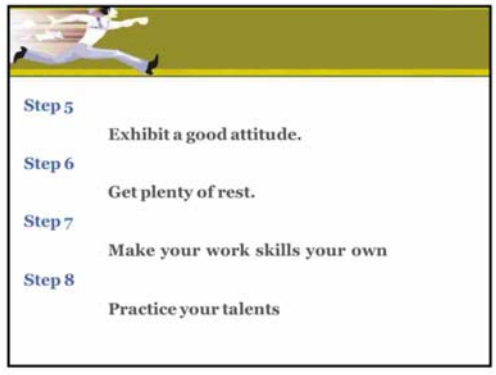
12 Steps to High Self-Esteem

Step 1
Forgive yourself for past mistakes.

Step 2
Focus on your positive attributes.

Step 3
Follow the example of successful people.

Step 4
Become a self talker.



Step 5
Exhibit a good attitude.

Step 6
Get plenty of rest.

Step 7
Make your work skills your own

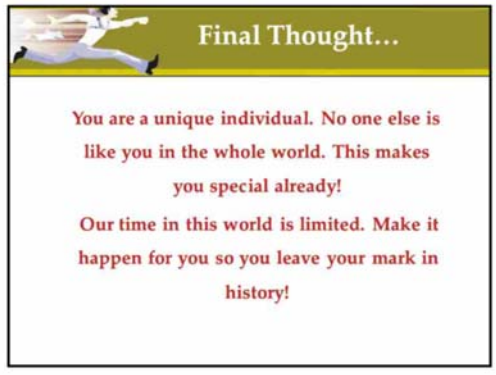
Step 8
Practice your talents

Step 9
Become physically fit.

Step 10
Learn new things.

Step 11
Improve your personal relationships.

Step 12
Dress well!



Final Thought…

You are a unique individual. No one else is like you in the whole world. This makes you special already!

Our time in this world is limited. Make it happen for you so you leave your mark in history!

APPENDIX – XXII

DATA CODE SHEET

AG – Age in years

1.1 ≤ 20 years

1.2 21- 30 years

1.3 31-40 years

1.4 41-50 years

1.5 > 50 years

ED - Educational status

2.1 Non literate

2.2 Primary education

2.3 Secondary education

2.4 Higher Secondary

2.5 Graduate & above

OC - Occupation

3.1 Unemployed

3.2 Student

3.3 Business

3.4 Labourers

3.6 Employed in some organisation

3.7 Retired

3.8 If others, Specify

MS - Marital status

4.1 Unmarried

4.2 Married

4.3 Separated

4.4 Divorced.

4.5 Widower

MI - Monthly family income

5.1 ≤10,000

5.2 10,001 – 20,000

5.3 20,001 – 30,000

5.4 30,001 – 40,000

NC - Number of children

6.1 Not applicable

6.2 No children

6.3 One

6.4 Two

6.5 More than two

RN -Religion

7.1 Hindu

7.2 Muslim

7.3 Christian

7.4 Others (specify)

TF - Type of the family

8.1 Nuclear

8.2 Joint

8.3 Extended

Family history of alcohol abuse/ dependence

9.1 Yes

9.2 No

10. If yes, Specify the relationship

FR - Father

BR- Brother

SN - Son

UL - Uncle

BL – Brother in law

CLINICAL VARIABLES

AS - Age at which the alcohol consumption was started (in years)

1.1 ≤20

1.2 21-25

1.3 26-30

1.4 >30

DA - Duration of alcohol dependence (in yrs)

2.1 ≤10

2.2 11-20

2.3 21-30

2.4 31-40

2.5 >40

PF- Precipitating factor for alcohol consumption

PP- Peer pressure / Influence

CY- Curiosity

RS- Religious / Social acceptance

FP- Family Problems

FI- Financial Problems

LT - Like the taste

EP - For Enjoyment/ Pleasure

FE - To forget or escape from problems

SU - Seeing others using

AL - To manage feelings of anger, loss or other emotional pain

FG – Fatigue

EW - Excessive Worries

IM - Insomnia

AF - Academic Failure

DC -Difficulty in concentrating

SH - To be smart (Heroism)

LI - Lack of interest in day to day life

SC - To have self- confidence

OS - Overcome shyness

PC- Pain / Other Physical Complaints

AN – Acculturation

PT- Poverty

UT – Unemployment

IC – Influence of cinema

OS – If others, specify

FA - Feelings when you first consumed alcohol

EX - Excited

RP - Relieved from all the problems

RD - Very relaxed

DC - Discomfort

OS- If others, Specify

SC - Situations that provoke you to consume more amount of alcohol

PI - Peer pressure / Influence

WL - Work load

TN - Tension

AX - Anxiety

TP - Thinking about any problems

SU - Seeing others using

PA - Presence of other abusers

SA - Sight of alcohol

SG - Shooting Gallery/Alcohol taking restaurant

AD - Advertisements

PP - Pain/ Other Physical Problems

SD - Sleep disturbances

EL - Eating less

SO - Any special occasion

OS - If others, Specify

FC - Frequency of alcohol consumption

6.1 Everyday

6.2 Several times a week

6.3 Once a week

6.4 Once a month

6.5 Less than once a month

FA - Form of alcohol used

CL - Country liquor

BD - Brandy

BE - Beer

WN - Wine

SR - Spirits (Gin, Vodka, Whisky etc)

RM - Rum

OS - If others, Specify

AA - Amount of alcohol consumed in a day (in ml)

8.1 ≤ 250

8.2 251-500

8.3 501-750

8.4 >750

MA –Money spent on alcohol consumption per day

9.1 ≤ 250

9.2 251-500

9.3 501-750

9.4 >750

SM - Source of money to buy alcohol

FL - Family

FS - Friends

SB - Selling Belongings

ST - Stealing from family and friends

OE – Own earning

OS – If others, specify

HA - History of usage of other addictive Agents

TS - Tobacco smoking

CC – Cocaine

CS - Cannabis

HN - Heroin

OS - If others, Specify

AS - Any associated symptoms

TH - Tremor in hands and fingers

FC - Feeling of choking

NS – Nervousness

SD – Sleep disturbances

EL – Eating less

MD- Memory disturbances

HV- Hearing voices/ Seeing things when alone

OS - If others, Specify

HC - History of associated complications

HD - Heart diseases

DS - Diabetes

LD - Lung disease

PN - Peripheral neuropathy

LI - Liver disease

S – Cancers

BD - Birth defects

DN – Depression

OS - If others, Specify

PC - Problems arisen due to alcohol consumption
CR - Conflicts in relationship
TW - Trouble at work
LT - Legal trouble
DR - Disturbing reputation
FS - Financial difficulties
OS- If others, Specify
EQ - Efforts to quit or cut down alcohol in the past
15.1 Yes
15.2 No
HA - History of abstinence
16.1 Yes
16.2 No
RA - Reason for restarting alcohol consumption
DI - Difficulty in concentration
LP - Loss of pleasure
CG - Craving
MW - To manage withdrawal symptoms
PR - Peer pressure / Influence
EN - Experimentation
CI - Controlled intake
OS - If others, specify

PD - Previous history of Alcoholics De-Addiction Treatment
19.1 Yes
19.2 No
BE- Belief in effectiveness of alcohol de-addiction treatment in dealing with addiction
20.1 Yes
20.2 No
HP - History of Psychiatric Hospitalisation
21.1 Yes
21.2 No
MT - Motivation to seek treatment
WI - Wish to improve oneself
AA - Availability and awareness of treatment
FE - Family pressure
FY - Family responsibility
SD - Social disapproval
DG - Difficulty in getting substance
FP - Fear of physical illness
DP - Development of physical illness
FJ - Fear of loss of job
RV - Due to religious values
OR - Observing recovered ones
FU - Fed up of using alcohol
NF - Reasons for which alcohol was used was not fulfilled
IA - Financial difficulties (Inability to afford)
AC - Accidents
OS - If others, specify
SI - Source of information regarding treatment
GP - General Practitioner
CP -Community health personnel including nurses
ST - Someone who had undergone treatment and has fully recovered now
FN - Family, Neighbours
FR - Friends
RT - Radio, Television, Newspaper
FH - Faith Healers
OS - If Others, Specify

SE- Self-Esteem
BA- Before AST
AA- After AST
AS- Assertiveness skills
BA- Before AST
AA- After AST
LS- Level of Satisfaction

APPENDIX - XXIII

MASTER CODE SHEET

CONTROL GROUP

	DEMOGRAPHIC VARIABLES														CLINICAL VARIABLES													
SN	AG	ED	OC	MS	MI	NC	RN	TF	FH	RS					AS	DA	PF											
										FR	BR	SN	UL	BL			PP	CY	RS	FP	FI	LT	EP	FE	SU	AL	FG	EW	IM	AF
1	1.4	2.2	3.4	4.2	5.2	6.5	7.1	8.2	9.2	0	0	0	0	0	1.3	2.2	1	0	1	0	0	0	1	0	0	0	0	0	0	0
2	1.2	2.3	3.3	4.1	5.1	6.1	7.1	8.1	9.1	1	0	0	0	0	1.1	2.1	0	0	0	0	1	0	1	1	0	1	0	1	0	0
3	1.4	2.3	3.4	4.1	5.1	6.1	7.1	8.1	9.2	0	0	0	0	0	1.1	2.3	0	1	0	0	1	0	1	1	0	1	0	1	1	0
4	1.3	2.4	3.3	4.1	5.2	6.1	7.1	8.2	9.1	1	0	0	0	0	1.1	2.2	1	1	0	1	1	1	1	1	0	1	1	1	1	1
5	1.3	2.5	3.5	4.2	5.2	6.4	7.1	8.1	9.2	0	0	0	0	0	1.1	2.2	1	0	0	0	0	0	0	0	0	0	0	0	0	0
6	1.5	2.5	3.7	4.2	5.1	6.4	7.3	8.3	9.1	1	0	0	0	0	1.2	2.4	1	0	0	0	0	0	1	0	0	0	0	0	0	0
7	1.4	2.4	3.3	4.2	5.1	6.2	7.2	8.2	9.2	0	0	0	0	0	1.4	2.2	1	1	0	0	1	1	1	1	0	1	0	0	1	0
8	1.1	2.3	3.4	4.1	5.1	6.1	7.2	8.2	9.1	1	0	0	0	0	1.1	2.1	1	0	0	0	0	0	1	0	0	0	0	0	0	0
9	1.5	2.4	3.7	4.1	5.1	6.1	7.1	8.2	9.1	0	1	0	0	0	1.4	2.3	0	0	0	1	0	0	0	0	0	0	0	0	0	0
10	1.2	2.4	3.1	4.1	5.3	6.1	7.3	8.2	9.2	0	0	0	0	0	1.2	2.1	1	0	0	0	0	0	0	0	0	1	0	0	0	1
11	1.5	2.5	3.7	4.2	5.4	6.3	7.3	8.3	9.2	0	0	0	0	0	1.2	2.1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
12	1.3	2.5	3.6	4.4	5.4	6.3	7.1	8.2	9.2	0	0	0	0	0	1.4	2.1	1	1	1	0	1	1	1	1	0	1	0	1	0	0
13	1.2	2.5	3.3	4.1	5.3	6.1	7.1	8.3	9.1	0	1	0	0	0	1.1	2.1	0	0	0	0	0	0	1	0	1	1	0	0	0	0
14	1.2	2.3	3.1	4.1	5.2	6.1	7.1	8.1	9.1	0	1	0	0	0	1.1	2.2	1	0	0	0	0	0	1	0	0	0	0	0	0	1
15	1.3	2.5	3.6	4.1	5.1	6.1	7.1	8.2	9.2	0	0	0	0	0	1.3	2.1	0	1	0	0	0	0	0	0	0	1	0	0	0	0
16	1.3	2.2	3.3	4.2	5.1	6.5	7.1	8.2	9.1	0	0	0	0	1	1.1	2.2	1	1	0	0	0	0	1	0	0	0	0	0	0	0
17	1.2	2.4	3.3	4.1	5.2	6.1	7.3	8.2	9.1	0	1	0	0	0	1.1	2.3	0	1	0	1	1	0	1	1	1	1	1	1	0	0
18	1.2	2.3	3.1	4.1	5.1	6.1	7.1	8.1	9.1	0	0	0	1	0	1.1	2.1	0	0	0	0	0	0	1	0	0	1	0	0	0	0
19	1.5	2.5	3.6	4.2	5.2	6.4	7.1	8.1	9.2	0	0	0	0	0	1.1	2.4	0	0	0	0	0	1	1	1	0	0	0	0	0	0
20	1.5	2.4	3.7	4.2	5.2	6.4	7.1	8.2	9.1	0	0	1	0	0	1.2	2.2	0	1	0	1	0	1	1	1	0	0	0	0	0	0
21	1.2	2.4	3.4	4.2	5.1	6.4	7.1	8.3	9.1	1	0	0	0	0	1.1	2.1	1	1	0	0	0	1	1	0	0	0	0	0	0	0
22	1.3	2.5	3.6	4.2	5.4	6.4	7.1	8.3	9.1	0	1	0	0	0	1.1	2.2	1	1	0	0	0	1	1	0	0	0	0	0	0	0
23	1.4	2.4	3.4	4.1	5.3	6.1	7.1	8.3	9.2	0	0	0	0	0	1.4	2.1	0	0	0	1	0	0	1	0	0	0	0	0	0	0
24	1.2	2.5	3.4	4.1	5.3	6.1	7.1	8.3	9.1	1	0	0	0	0	1.1	2.1	0	0	0	0	0	0	1	0	0	0	0	0	0	1
25	1.5	2.5	3.7	4.2	5.2	6.3	7.1	8.2	9.2	0	0	0	0	0	1.2	2.4	0	0	0	0	0	0	1	0	0	0	0	0	0	0
26	1.1	2.4	3.4	4.1	5.1	6.1	7.3	8.1	9.1	1	0	0	0	0	1.1	2.1	1	1	0	1	0	1	1	1	1	0	0	1	0	0
27	1.1	2.5	3.1	4.1	5.2	6.1	7.4	8.2	9.1	1	0	0	0	0	1.1	2.1	1	1	0	1	1	1	1	0	1	1	1	1	0	1
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30	1.2	2.5	3.6	4.1	5.4	6.1	7.3	8.1	9.1	1	0	0	0	0	1.1	2.1	1	0	0	0	0	0	0	0	0	0	0	0	0	1

												FA					SC													
DC	SH	LI	SC	OS	LF	PC	AN	PT	UT	IC	OS	EX	RP	RD	DC	OS	PI	WL	TN	AX	TP	SU	PA	LT	DT	SA	SG	AD	PP	SO
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1	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0	0	1	0	0	0	0	1

	FC	FA							AA	MA	SM						HA					AS								HC
OS		CL	BD	BE	WN	SR	RM	OS			FL	FS	SB	ST	OE	OS	TS	CC	CS	HN	OS	TH	FC	NS	SD	EL	MD	HV	OS	HD
1	6.1	0	1	0	0	0	0	0	8.2	9.2	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
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0	6.1	1	1	1	1	1	1	0	8.2	9.1	1	1	1	1	1	1	0	0	0	0	1	1	0	1	1	0	0	1	0	0
0	6.1	1	1	1	1	1	1	0	8.3	9.2	1	1	0	0	1	0	1	0	0	0	0	1	0	1	0	1	0	0	0	0
0	6.1	0	1	0	1	0	0	0	8.1	9.1	1	0	0	0	1	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0
1	6.1	0	1	0	0	0	0	0	8.1	9.1	1	0	0	0	1	1	0	0	0	0	0	0	0	1	1	1	0	0	0	1
0	6.3	0	1	1	1	1	1	0	8.1	9.2	0	0	0	0	1	1	1	0	1	0	1	0	0	0	0	1	0	0	0	0
0	6.1	0	1	0	0	0	1	0	8.1	9.1	0	1	0	0	1	0	1	0	0	0	0	1	0	1	1	1	0	0	0	1
0	6.2	0	1	1	0	0	0	0	8.2	9.2	1	1	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
0	6.3	0	1	0	0	0	0	0	8.1	9.1	0	0	0	0	1	0	1	0	0	0	0	1	0	0	0	1	0	0	0	1
0	6.2	0	1	1	0	0	0	0	8.2	9.1	1	1	0	0	1	0	0	0	0	0	0	1	1	1	1	1	0	0	0	0
0	6.2	0	1	0	0	1	1	1	8.2	9.1	1	1	0	0	1	0	1	0	0	0	0	1	0	1	1	1	0	0	0	0
1	6.1	1	1	1	1	1	1	0	8.4	9.2	0	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	0	0	1	0
0	6.3	0	1	1	1	0	1	0	8.2	9.1	1	0	0	0	1	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0
0	6.2	1	1	1	1	1	1	0	8.2	9.2	1	1	0	0	1	0	0	0	0	1	1	1	0	1	0	0	0	0	0	0
0	6.1	0	1	1	1	1	1	0	8.2	9.1	1	1	1	1	1	0	1	0	0	0	0	1	0	0	1	1	1	0	0	0
0	6.1	0	0	0	0	0	1	0	8.3	9.1	1	1	1	1	0	0	1	0	0	0	0	1	0	1	0	1	0	0	0	0
0	6.1	0	0	0	0	0	1	0	8.2	9.1	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1	0	1
0	6.1	0	1	0	0	0	0	0	8.2	9.1	0	0	0	0	1	0	1	0	0	0	0	1	0	1	1	1	1	0	0	1
1	6.1	0	1	0	0	0	0	0	8.1	9.4	0	0	1	1	1	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0
1	6.1	0	1	1	0	1	1	0	8.2	9.4	1	0	1	1	1	0	1	0	1	1	1	1	1	0	1	1	1	0	0	0
0	6.1	0	0	0	0	0	1	0	8.4	9.4	1	0	0	0	1	0	1	0	1	1	1	1	0	1	1	1	1	1	0	0
0	6.1	0	0	1	0	0	1	0	8.2	9.1	0	0	0	0	1	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0
0	6.3	0	0	0	0	0	1	0	8.2	9.4	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0
1	6.1	1	1	1	1	1	1	0	8.1	9.2	0	1	0	0	1	0	1	0	0	0	0	0	0	0	0	1	0	1	0	0
1	6.1	0	0	1	1	1	1	0	8.2	9.2	1	1	1	1	1	0	1	0	1	1	1	1	1		1	1	0	0	0	0
1	6.2	0	0	0	0	0	0	0	8.1	9.1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0
0	6.1	1	1	0	0	1	0	1	8.1	9.2	0	1	0	0	1	0	1	1	0	0	0	1	0	0	0	1	0	0	0	0
0	6.2	0	1	0	0	0	0	0	8.2	9.2	1	1	1	1	1	0	1	0	0	0	0	1	0	0	1		1	1	0	0
0		0	0	1	1	1	0	0	8.2	9.1	1	1	0	0	1	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0

HC								PC						EQ	HA	RA								PD	BE	HP	MT			
DS	LD	PN	LI	CS	BD	DN	OS	CR	TW	LT	DR	FS	OS			DI	LP	CG	MW	PR	EN	CI	OS				WI	AA	FE	FY
0	0	0	0	0	0	0	0	1	0	0	0	1	1	15.2	16.2	0	1	0	0	0	0	0	0	19.2	20.1	21.2	0	0	0	1
0	1	0	0	1	0	1	0	1	1	0	1	1	0	15.1	16.1	1	1	0	0	0	1	1	0	19.1	20.2	21.2	1	0	0	1
0	0	0	1	0	0	1	0	1	1	1	1	1	0	15.2	16.2	0	1	1	1	1	0	0	0	19.1	20.2	21.1	1	1	1	1
0	0	0	0	0	0	1	0	1	1	0	0	0	0	15.1	16.1	0	1	1	0	0	0	0	0	19.1	20.1	21.1	1	1	0	1
0	0	0	0	0	0	0	0	1	1	0	1	0	0	15.1	16.1	0	0	0	0	1	0	0	0	19.2	20.1	21.1	0	0	1	1
0	0	0	0	0	0	1	0	0	0	0	0	1	0	15.1	16.1	0	1	0	0	1	0	0	0	19.1	20.1	21.2	0	0	1	1
0	0	0	0	0	0	0	0	0	0	0	0	0	0	15.1	16.1	0	0	0	1	0	0	0	0	19.2	20.1	21.2	0	0	1	1
0	0	0	0	0	0	1	0	1	0	0	0	0	0	15.1	16.1	0	0	0	0	1	0	0	0	19.1	20.1	21.2	0	0	0	1
0	0	0	0	0	0	1	0	0	0	0	0	1	0	15.1	16.1	0	0	0	0	0	1	0	0	19.2	20.1	21.2	0	0	0	1
1	0	0	0	0	0	1	0	1	0	0	0	0	0	15.1	16.1	0	1	1	0	1	1	0	0	19.1	20.1	21.1	0	0	0	1
0	0	0	0	1	0	0	1	1	0	1	1	0	0	15.1	16.1	1	1	0	1	0	0	0	0	19.2	20.1	21.2	0	0	1	0
0	0	0	1	0	0	1	0	1	1	0	1	1	0	15.1	16.1	0	0	0	0	0	0	0	1	19.1	20.2	21.2	1	0	0	1
0	0	0	0	0	0	0	0	1	1	1	1	1	0	15.1	16.1	0	0	0	0	0	1	0	0	19.1	20.1	21.2	1	0	0	1
0	0	0	0	0	0	1	0	0	1	0	0	0	0	15.1	16.1	0	0	0	0	1	0	0	1	19.1	20.1	21.2	0	0	0	1
0	0	0	0	0	0	0	0	1	1	1	1	1	0	15.1	16.1	0	0	0	0	0	1	1	0	19.1	20.1	21.1	1	0	1	1
0	0	0	0	0	0	1	0	1	1	0	0	1	0	15.1	16.1	0	0	0	0	0	0	1	0	19.1	20.1	21.2	1	0	1	1
0	0	0	0	0	0	0	0	1	1	0	0	0	0	15.1	16.1	0	0	1	0	0	0	0	1	19.1	20.1	21.2	1	1	0	1
0	0	0	0	0	0	1	0	0	0	0	1	0	0	15.1	16.1	0	1	0	1	0	0	0	0	19.1	20.1	21.1	0	0	0	1
0	0	0	0	0	0	1	0	1	0	0	0	0	0	15.1	16.1	0	0	0	0	1	0	1	0	19.1	20.1	21.1	0	0	0	1
0	0	0	0	0	0	0	0	1	0	1	0	0	0	15.1	16.1	0	0	1	0	0	0	0	1	19.2	20.1	21.2	1	0	0	1
0	0	0	0	1	0	0	0	1	0	0	1	1	0	15.1	16.1	0	0	1	0	0	1	1	0	19.1	20.1	21.1	0	0	1	1
0	0	0	0	1	0	0	0	1	0	1	1	1	0	15.1	16.1	0	1	0	0	0	0	0	0	19.1	20.1	21.1	1	0	1	0
0	0	0	0	0	0	0	0	1	1	0	0	0	0	15.1	16.1	0	0	0	0	0	0	1	0	19.2	20.2	21.2	1	0	0	0
0	0	0	0	0	0	0	0	1	0	0	0	0	0	15.1	16.1	1	1	0	0	1	1	1	0	19.2	20.2	21.2	1	0	0	0
0	0	0	0	0	0	0	0	1	1	0	1	0	0	15.1	16.1	0	0	1	0	0	0	1	0	19.1	20.1	21.1	1	0	1	0
0	0	0	0	0	0	0	0	1	1	1	1	1	0	15.1	16.1	1	0	1	0	0	0	0	0	19.1	20.1	21.2	1	1	0	0
0	0	0	0	0	0	0	0	1	0	0	1	0	0	15.1	16.1	0	1	0	0	1	0	1	0	19.1	20.1	21.2	1	0	0	1
1	0	0	0	0	0	0	0	0	0	0	1	0	0	15.1	16.1	0	0	1	0	1	0	0	0	19.1	20.1	21.2	1	0	0	0
0	0	0	1	1	0	0	0	1	1	0	0	0	0	15.1	16.1	0	0	1	0	0	1	0	0	19.1	20.1	21.2	0	1	1	0
0	0	0	0	0	0	0	0	1	0	0	1	1	0	15.1	16.1	0	0	0	0	0	0	0	0	19.1	20.1	21.2	1	0	0	1

MT												SI								SE		AS	
SD	DG	FP	DP	FJ	RV	OR	FU	NF	IA	AC	OS	GP	CP	ST	FN	FR	RT	FH	OS	BA	AA	BA	AA
0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	20	16	-15	-13
1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	24	19	-12	-14
1	1	0	0	0	0	0	0	0	1	1	0	1	0	1	1	1	1	1	0	22	20	-8	-8
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	0	18	19	-6	-10
0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	12	14	-3	-2
1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	16	19	-20	-25
0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	18	19	-12	-11
0	0	1	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	13	14	16	15
0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	20	17	-27	-25
0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	17	20	-2	-2
0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	14	15	25	26
1	0	0	0	0	0	1	0	0	0	1	0	1	0	0	1	0	1	1	0	23	25	-12	-11
0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	13	14	-9	-11
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	19	16	20	20
1	0	1	1	1	0	1	1	1	1	1	0	1	1	1	1	1	1	1	0	12	14	-4	-4
1	0	1	0	1	1	0	1	0	0	0	0	1	1	1	1	0	0	1	1	19	17	4	4
1	1	1	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0	18	19	9	12
1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	14	8	-2	2
0	0	1	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	20	20	-5	-6
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	19	15	12	13
0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	16	20	-12	-10
1	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	1	22	20	-23	-25
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	17	16	-7	-9
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	13	16	-12	-12
1	0	0	0	0	0	0	1	0	0	0	0	1	1	0	0	0	0	0	1	10	17	1	-1
0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	12	16	6	6
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	17	20	17	18
1	0	0	0	0	0	0	1	1	0	0	0	0	1	1	1	0	0	0	0	18	18	7	8
1	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0	1	1	16	17	8	7
0	0	1	0	0	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	16	21	-8	-10

MASTER CODE SHEET																														
EXPERIMENTAL GROUP																														
	DEMOGRAPHIC VARIABLES															CLINICAL VARIABLES														
SN	AG	ED	OC	MS	MI	NC	RN	TF	FH	RS					AS	DA	PF													
										FR	BR	SN	UL	BL			PP	CY	RS	FP	FI	LT	EP	FE	SU	AL	FG	EW	IM	AF
1	1.1	2.5	3.3	4.1	5.1	6.1	7.1	8.2	9.1	1	0	0	0	0	1.1	2.1	1	1	0	0	0	1	1	1	0	0	0	1	1	1
2	1.2	2.5	3.5	4.1	5.2	6.1	7.1	8.2	9.1	1	0	0	0	0	1.2	2.1	1	1	0	0	0	1	1	0	0	0	0	0	0	0
3	1.2	2.2	3.4	4.2	5.4	6.5	7.1	8.2	9.1	1	1	0	0	0	1.3	2.1	1	1	0	0	0	0	0	0	1	0	0	0	0	0
4	1.2	2.5	3.4	4.4	5.3	6.2	7.1	8.2	9.1	0	1	0	0	0	1.1	2.3	1	1	0	0	0	0	1	1	1	1	1	1	1	0
5	1.2	2.2	3.3	4.2	5.1	6.2	7.1	8.1	9.2	0	0	0	0	0	1.3	2.1	0	1	0	0	0	0	1	0	0	0	0	0	0	0
6	1.4	2.3	3.5	4.2	5.3	6.4	7.1	8.2	9.2	0	0	0	0	0	1.2	2.3	0	1	0	0	0	0	0	0	0	0	0	0	0	0
7	1.3	2.3	3.3	4.2	5.1	6.4	7.1	8.1	9.2	0	0	0	0	0	1.1	2.3	0	1	0	0	0	0	0	0	0	0	0	0	0	0
8	1.2	2.5	3.5	4.2	5.4	6.4	7.1	8.1	9.1	1	1	0	0	0	1.1	2.2	0	1	0	1	1	0	1	1	0	1	1	1	1	0
9	1.2	2.2	3.1	4.3	5.1	6.2	7.1	8.1	9.2	0	0	0	0	0	1.3	2.1	1	1	0	0	0	0	1	0	0	0	0	0	0	0
10	1.1	2.3	3.3	4.1	5.1	6.1	7.1	8.2	9.1	1	0	0	0	0	1.1	2.1	0	1	0	0	0	0	0	1	1	0	0	0	0	0
11	1.4	2.5	3.7	4.5	5.1	6.5	7.1	8.1	9.1	1	0	0	0	0	1.1	2.5	0	1	0	0	0	0	1	0	0	1	0	0	0	0
12	1.2	2.2	3.2	4.1	5.1	6.1	7.2	8.1	9.2	0	0	0	0	0	1.1	2.2	0	0	0	0	0	0	1	0	0	0	0	0	0	0
13	1.1	2.4	3.5	4.2	5.1	6.3	7.1	8.2	9.1	1	0	0	0	0	1.2	2.1	0	0	0	0	0	0	1	1	0	1	0	1	0	0
14	1.4	2.5	3.7	4.3	5.1	6.2	7.3	8.1	9.1	0	0	1	0	0	1.2	2.4	0	1	0	0	0	0	1	1	0	1	1	0	0	0
15	1.2	2.5	3.5	4.2	5.1	6.3	7.1	8.3	9.1	1	0	0	0	0	1.1	2.3	1	0	0	0	0	1	1	0	0	1	0	1	0	0
16	1.4	2.5	3.7	4.2	5.2	6.4	7.1	8.1	9.2	0	0	0	0	0	1.4	2.1	0	1	0	0	0	0	1	0	0	0	0	0	1	0
17	1.2	2.2	3.4	4.2	5.1	6.2	7.1	8.2	9.2	0	0	0	0	0	1.2	2.2	0	0	0	0	0	0	1	0	0	0	0	0	0	0
18	1.2	2.3	3.4	4.2	5.1	6.3	7.1	8.1	9.1	1	0	0	0	0	1.1	2.2	1	1	0	0	0	1	1	0	0	0	0	0	0	0
19	1.2	2.4	3.7	4.2	5.2	6.5	7.1	8.2	9.2	0	1	0	0	0	1.2	2.1	0	0	0	1	0	0	0	1	0	1	1	1	1	0
20	1.2	2.4	3.3	4.2	5.2	6.2	7.1	8.1	9.1	1	0	0	0	0	1.1	2.2	0	1	0	1	1	1	1	1	0	1	1	1	0	1
21	1.1	2.2	3.4	4.2	5.1	6.2	7.1	8.2	9.1	1	0	0	0	0	1.2	2.1	0	0	0	1	0	1	1	1	1	1	1	1	0	0
22	1.1	2.4	3.3	4.2	5.1	6.2	7.1	8.1	9.1	0	1	0	0	0	1.2	2.1	0	0	0	0	0	0	1	0	0	0	0	0	0	0
23	1.3	2.2	3.4	4.2	5.1	6.4	7.1	8.1	9.1	1	0	0	0	0	1.3	2.3	1	1	0	0	0	1	1	0	0	0	0	0	0	1
24	1.2	2.3	3.4	4.5	5.1	6.3	7.1	8.1	9.1	0	1	0	0	0	1.1	2.2	1	0	0	0	0	0	1	1	0	0	0	0	0	0
25	1.3	2.4	3.3	4.2	5.2	6.4	7.2	8.2	9.1	0	1	0	0	0	1.2	2.3	1	1	0	0	0	0	0	0	1	1	0	0	0	0
26	1.2	2.5	3.6	4.2	5.2	6.3	7.3	8.1	9.2	0	0	0	0	0	1.1	2.3	1	0	0	0	0	0	1	0	0	0	1	0	0	0
27	1.2	2.4	3.4	4.2	5.1	6.3	7.1	8.2	9.2	0	0	0	0	0	1.1	2.2	1	1	0	0	0	1	0	0	0	0	0	1	0	0
28	1.3	2.4	3.3	4.2	5.2	6.5	7.1	8.2	9.1	1	0	0	0	0	1.3	2.2	1	0	0	0	0	0	0	0	0	1	0	0	0	0
29	1.4	2.5	3.3	4.2	5.3	6.5	7.1	8.2	9.1	1	0	0	0	0	1.1	2.4	1	0	0	0	1	1	0	0	0	0	0	0	0	0
30	1.2	2.5	3.7	4.4	5.2	6.3	7.1	8.2	9.1	0	1	0	0	0	1.1	2.2	0	1	0	0	0	0	0	0	0	0	0	0	0	1

												FA					SC													
DC	SH	LI	SC	OS	LF	PC	AN	PT	UT	IC	OS	EX	RP	RD	DC	OS	PI	WL	TN	AX	TP	SU	PA	LT	DT	SA	SG	AD	PP	SO
0	1	0	1	1	0	0	0	0	0	0	0	1	1	0	0	0	1	1	0	0	0	0	0	1	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	1	1	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	0	0	0	1	0	1	1	1	1	0	1	0
0	0	1	0	1	1	1	0	0	0	0	0	1	0	0	0	0	1	1	1	1	1	1	0	1	1	1	1	1	1	1
0	0	1	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	1
0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	0	0	1	0	1	0	0	0	0	0	1
0	0	0	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	1	0	0	0	1	0	0	0	0	1
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0
0	0	1	1	1	0	0	0	1	1	1	0	1	0	0	0	0	0	1	1	1	1	1	1	0	1	1	0	0	1	0
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0
0	1	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	0	0	0	1	1	0	0	0	0	0	0	0	0
0	0	1	1	0	0	0	0	0	0	0	0	1	0	1	0	0	0	1	0	0	0	1	0	0	1	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
0	0	0	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1	0	1	0	1	1	1	0	0	0	1
0	0	1	1	1	0	1	0	0	0	0	0	1	1	1	0	0	0	0	1	1	1	0	1	1	1	1	0	0	1	1
1	0	1	1	1	1	1	1	0	0	0	0	1	1	1	0	0	0	1	1	1	1	1	1	1	1	1	1	0	1	1
0	1	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
0	1	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	0	0	0	1	0	0	1	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	1
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	0	0	1	0	0	0	0	1	0	0	1	1	1	0	0	0
0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0
0	0	1	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	1	0	0	0	1	1	0	1	0	0	0	0	1
0	0	0	0	0	1	0	0	0	0	1	0	0	1	0	0	0	1	0	0	1	0	0	0	0	0	1	0	0	0	0
0	1	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	0	0	1	0	1	0	0	0

	FC	FA							AA	MA	SM						HA					AS								HC
OS		CL	BD	BE	WN	SR	RM	OS			FL	FS	SB	ST	OE	OS	TS	CC	CS	HN	OS	TH	FC	NS	SD	EL	MD	HV	OS	HD
0	6.5	1	1	1	1	0	1	0	8.2	9.1	0	0	0	0	1	0	1	0	0	0	0	1	0	1	1	1	0	0	0	0
0	6.4	1	0	0	0	0	0	0	8.1	9.1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
0	6.1	0	1	0	0	0	0	0	8.2	9.1	1	0	0	0	1	0	1	0	1	0	0	1	0	0	1	1	1	0	0	0
0	6.1	0	1	1	0	1	1	0	8.2	9.2	1	1	1	0	1	0	1	0	0	0	0	1	0	1	1	0	1	0	0	0
0	6.4	0	1	0	0	0	0	0	8.1	9.1	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
0	6.2	0	1	0	0	0	0	0	8.2	9.2	1	0	0	0	1	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0
0	6.1	0	1	0	0	0	0	0	8.3	9.2	0	0	0	0	1	0	0	0	0	0	1	1	0	1	0	1	1	0	0	0
0	6.2	1	1	1	0	1	1	0	8.3	9.3	1	1	0	0	1	0	1	0	0	0	0	1	0	0	1	1	1	0	0	0
1	6.1	0	1	0	0	0	0	0	8.3	9.2	1	0	1	0	1	1	1	0	0	0	0	0	0	0	1	1	0	0	1	0
0	6.1	0	1	0	0	0	1	0	8.2	9.1	0	1	1	0	1	0	1	0	0	0	0	1	0	1	1	1	1	0	0	0
0	6.1	0	1	0	0	0	0	0	8.2	9.1	0	0	0	0	1	0	0	0	0	0	0	1	0	1	0	0	1	0	0	0
1	6.5	0	1	1	0	0	0	0	8.1	9.1	1	0	1	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0
1	6.1	1	0	1	0	0	0	0	8.1	9.1	1	0	0	0	0	0	0	0	0	0	1	1	1	1	1	0	1	1	0	0
0	6.1	0	1	0	0	0	1	0	8.3	9.2	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0
0	6.1	1	1	1	1	1	1	0	8.3	9.1	1	0	1	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
0	6.2	0	1	0	1	1	0	0	8.2	9.2	0	0	0	0	1	0	0	0	0	0	1	1	0	0	1	1	1	1	0	0
0	6.3	0	0	1	0	0	0	0	8.3	9.1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	6.2	0	1	1	0	0	0	0	8.1	9.1	1	1	1	0	1	0	1	0	0	0	1	1	0	0	0	1	0	0	0	0
0	6.2	0	1	0	0	0	0	0	8.3	9.1	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0
0	6.1	1	1	1	0	1	1	0	8.4	9.2	1	0	1	1	1	0	1	0	1	0	1	1	1	1	1	1	1	1	0	0
0	6.1	1	1	1	1	1	1	0	8.3	4.4	0	0	1	1	1	0	1	1	1	0	0	1	1	0	1	1	1	1	0	0
1	6.4	0	1	1	0	0	0	0	8.2	9.2	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
1	6.1	0	1	0	0	0	0	0	8.1	9.1	1	1	0	0	1	0	1	0	0	0	1	1	0	0	0	0	0	0	0	0
0	6.1	0	1	1	1	1	1	0	8.3	9.2	1	1	1	1	1	0	1	0	0	0	1	1	0	0	1	1	0	0	0	0
0	6.1	0	1	0	0	0	0	0	8.2	9.2	1	0	0	0	1	0	1	0	1	0	0	1	0	0	1	1	1	0	1	0
0	6.1	0	0	0	0	1	0	0	8.1	9.2	1	1	0	0	1	0	1	0	0	0	0	1	0	1	1	1	1	0	0	0
0	6.1	0	1	0	0	0	0	0	8.1	9.2	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
0	6.2	0	1	1	0	0	0	0	8.2	9.1	1	0	0	1	0	0	1	0	0	0	1	1	0	0	1	1	1	0	0	0
0	6.1	0	1	0	0	1	0	0	8.1	9.1	1	1	0	0	1	0	1	1	0	0	0	0	0	0	1	1	0	0	0	0
0	6.1	0	1	0	0	0	1	0	8.3	9.2	1	1	0	0	1	0	1	1	0	0	0	0	0	0	1	1	0	0	0	0

HC								PC						EQ	HA	RA								PD	BE	HP	MT			
DS	LD	PN	LI	CS	BD	DN	OS	CR	TW	LT	DR	FS	OS			DI	LP	CG	MW	PR	EN	CI	OS				WI	AA	FE	FY
0	0	1	0	0	1	0	0	1	0	0	0	0	0	15.2	16.2	0	1	0	0	1	1	1	0	19.1	20.1	21.1	0	1	1	0
0	0	0	0	0	0	0	0	1	0	0	0	0	0	15.2	16.2	0	0	0	0	0	0	1	0	19.2	20.2	21.2	1	0	0	0
0	0	0	0	1	0	0	0	1	0	0	1	0	0	15.1	16.1	0	0	1	1	0	1	1	0	19.1	20.1	21.2	0	0	0	1
0	0	0	0	0	0	0	0	1	0	0	0	0	0	15.1	16.1	0	1	1	1	1	0	1	0	19.1	20.1	21.1	1	0	1	1
0	0	0	0	0	0	0	0	1	0	0	0	0	0	15.1	16.1	0	1	0	0	0	0	0	0	19.1	20.1	21.1	0	0	0	1
0	0	0	0	0	0	0	0	1	1	0	1	1	0	15.1	16.1	0	0	0	0	0	1	0	0	19.1	20.1	21.2	1	0	0	1
0	1	0	0	0	0	0	0	1	0	0	0	1	0	15.1	16.1	0	1	0	0	0	0	1	0	19.2	20.2	21.2	0	0	0	1
0	0	0	1	1	0	0	0	1	1	0	1	1	0	15.1	16.1	1	0	0	0	0	0	1	0	19.2	20.2	21.2	1	0	0	1
0	0	0	0	1	0	1	0	1	1	0	1	1	0	15.2	16.2	0	0	0	0	0	0	0	0	19.2	20.2	21.2	0	0	0	0
0	0	0	0	1	0	0	0	1	1	0	1	1	0	15.2	16.2	0	1	0	1	0	0	1	0	19.2	20.2	21.2	0	0	0	1
1	0	0	1	0	0	0	0	0	0	0	1	0	0	15.1	16.1	0	0	1	0	0	0	0	0	19.1	20.1	21.1	0	0	0	0
0	0	0	0	0	0	0	0	1	0	1	0	0	0	15.2	16.2	0	0	0	0	0	0	0	0	19.2	20.2	21.2	1	0	0	0
0	0	0	0	0	0	1	0	1	1	1	1	0	0	15.1	16.1	0	1	0	1	0	0	0	0	19.1	20.1	21.1	0	0	0	1
0	0	0	0	0	0	1	0	1	0	0	0	0	0	15.1	16.1	0	1	0	0	0	0	0	0	19.1	20.1	21.2	1	0	0	0
0	0	0	0	1	0	1	0	1	1	0	1	0	0	15.1	16.1	1	0	1	0	0	0	0	0	19.1	20.1	21.2	1	0	0	1
0	0	0	0	0	1	1	0	1	0	0	1	0	0	15.1	16.1	0	0	0	0	0	0	1	0	19.1	20.1	21.2	0	0	0	1
0	0	0	0	0	0	0	1	0	0	0	0	0	0	15.2	16.2	0	0	0	0	0	0	0	0	19.2	20.2	21.2	0	0	0	1
0	0	0	0	0	0	0	0	1	0	0	0	0	0	15.1	16.1	0	1	0	0	0	0	0	0	19.1	20.1	21.2	1	0	0	1
0	0	0	0	0	0	1	0	1	0	0	1	0	0	15.1	16.1	1	1	1	0	0	0	1	0	19.1	20.1	21.2	1	0	0	1
0	1	1	0	1	1	1	0	1	1	1	1	1	0	15.1	16.1	1	1	0	1	0	1	1	0	19.1	20.1	21.1	1	1	0	1
0	0	0	0	0	0	1	0	1	1	1	1	1	0	15.1	16.1	1	1	1	1	0	1	0	0	19.1	20.1	21.1	1	1	0	0
0	0	0	0	0	0	0	0	0	1	0	0	1	0	15.1	16.1	0	0	0	0	0	0	0	0	19.1	20.1	21.2	0	0	0	0
0	0	0	0	0	1	0	0	1	0	0	1	0	0	15.1	16.1	0	0	1	0	0	1	1	0	19.1	20.1	21.2	0	0	0	1
0	0	0	0	0	0	0	0	1	0	0	0	1	0	15.1	16.1	0	0	1	0	1	1	1	0	19.1	20.1	21.2	0	0	0	1
0	0	0	0	1	0	0	0	1	0	0	1	0	0	15.1	16.1	0	0	1	1	0	1	1	0	19.1	20.1	21.2	0	0	0	0
0	0	1	0	1	0	0	0	1	0	0	1	1	0	15.1	16.1	0	1	1	0	1	0	0	0	19.2	20.2	21.2	1	0	0	0
0	0	0	0	0	0	0	0	1	0	0	0	0	0	15.1	16.1	1	0	1	0	0	0	0	0	19.1	20.1	21.2	0	0	0	1
0	0	0	0	1	0	0	0	0	1	0	1	0	0	15.2	16.2	0	1	1	0	1	1	0	0	19.2	20.2	21.2	1	0	0	0
0	0	0	0	0	0	0	0	1	1	0	1	1	0	15.1	16.1	1	0	1	0	1	0	1	0	19.1	20.1	21.2	1	0	0	1
0	0	0	0	0	0	0	0	1	0	0	1	0	0	15.1	16.1	0	1	1	0	0	0	0	0	19.1	20.1	21.2	1	1	0	0

MT												SI								SE		AS		LOS
SD	DG	FP	DP	FJ	RV	OR	FU	NF	IA	AC	OS	GP	CP	ST	FN	FR	RT	FH	OS	BA	AA	BA	AA	
0	0	1	0	1	0	1	1	1	1	1	0	0	0	1	1	1	0	0	0	20	24	-13	12	27
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	19	22	-11	19	26
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	17	21	-7	16	27
1	0	1	0	1	0	1	0	0	0	0	0	1	0	1	0	0	0	1	0	19	23	-10	18	26
0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	20	26	-11	14	27
0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	8	15	-5	24	27
0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	16	18	-14	12	28
1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	11	14	14	29	25
0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	8	23	-29	31	25
0	0	0	0	1	0	1	0	0	0	1	0	1	0	1	0	0	0	0	0	16	19	-3	28	27
0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	1	16	24	24	32	26
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	9	22	-13	13	27
1	0	1	0	1	0	1	0	0	0	1	0	1	0	1	0	1	1	0	0	13	21	-8	16	27
0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	19	20	21	40	25
0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1	0	0	0	15	20	-5	13	25
0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	23	28	3	19	25
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	19	23	8	38	25
0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	13	22	-5	16	27
1	0	1	0	0	0	1	1	0	0	1	0	0	0	0	0	1	1	1	0	20	27	-5	21	28
1	0	1	0	1	0	1	0	1	1	1	0	1	0	1	1	0	0	0	0	17	20	-8	23	27
0	1	1	0	0	0	1	0	0	1	1	0	1	1	1	0	1	0	1	0	20	26	-13	28	26
0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	18	27	-22	26	28
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	15	20	-6	32	29
0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	1	1	0	0	1	7	16	-13	28	28
0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	19	23	-2	46	28
0	0	1	0	0	0	0	1	0	0	0	0	1	0	1	0	0	0	0	0	14	22	8	23	28
0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	8	17	18	47	27
1	0	1	0	0	0	0	1	0	1	0	0	0	1	0	0	1	0	0	1	16	23	8	29	25
0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	17	24	6	25	25
1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	19	27	-6	27	25